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88-301

No.

In The Supreme Court

OF THE

United States

OCTOBER TERM, 1988

ZORA S. GILL, M.D.,
Petitioner

v.

MERCY HOSPITAL AND THE MEDICAL STAFF OF MERCY HOSPITAL,
Respondents.

PETITION FOR WRIT OF CERTIORARI TO THE CALIFORNIA COURT OF APPEAL AND APPENDIX

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QUESTIONS PRESENTED

1. Whether California's statutorily mandated physician "peer review" constitutes Fourteenth Amendment "state action"?

2. Whether the exclusion of a physician's retained counsel at "peer review" hearings, which affects a physician's ability to continue to practice medicine, violates the Due Process Clause?

3. Whether a statute which imposes a less stringent standard of judicial review of "peer review" adjudications made by private hospitals compared to those made by public hospitals violates the Equal Protection Clause?

4. Whether the participation, *ex parte*, of the charging party, the prosecution, in the private deliberations of the "peer review" committee violates the Due Process Clause?

5. Whether placing the burden of proof on the physician, in a peer review hearing, to disprove charges that he is unqualified to practice medicine, violates the Due Process Clause?

6. Whether a standard of proof, imposed upon a physician in a peer review proceeding, to establish by an "appropriate showing" violates the Due Process Clause?

TABLE OF CONTENTS

Page

QUESTIONS PRESENTED i

I.

INTRODUCTION 1

1. Opinion Below 1
2. Jurisdiction 2
3. Constitutional and Statutory Provisions 2

II.

STATEMENT OF THE CASE 2

III.

REASONS FOR GRANTING THE WRIT 5

A. California's Statutorily Mandated Physician "Peer Review" Constitutes The Fourteenth Amendment "State Action" 5

B. Due Process Entitles A Physician To Be Represented By Retained Counsel At "Peer Review" Hearings Affecting A Physician's Ability To Practice Medicine 10

1. A California Physician Has A Property Interest In Obtaining Full Medical Staff Privileges 11
2. A Peer Review Hearing Is Adversarial In Nature 16
3. The Due Process Clause Requires Procedural Protection At A Peer Review Hearing 17
4. The Interests Of The State 19
5. The Possibility Of An Erroneous Decision 20

C. California Code Of Civil Procedure Section 1094.5 Violates The Equal Protection Clause In Providing For A Less Stringent Standard Of Judicial Review Of Decisions Taken By Private Hospitals Than Those Taken By Public Hospitals 21

TABLE OF CONTENTS

Page

D. The Presence And Participation, Ex Parte, Of The Charging Party, The Prosecutor, In The Deliberations Of The Ad Hoc Committee Violates Due Process 24

E. Placing The Burden Of Proof On The Physician To Disprove The Allegations That He Is Unqualified, Using A Standard Of "Appropriate Showing", Violates Due Process 27

IV.

CONCLUSION 29

Appendices

Appendix A (Opinion Below) A-1

Appendix B (California Medical Association Amicus Curiae Letter to the Supreme Court of California... B-1

Appendix C (States that Mandate Peer Review by Statute) C-1

Appendix D (California Business and Professions Code Section 805) D-1

Appendix E (California Business and Professions Code Section 805.5) E-1

Appendix F (States that Require Reporting of Adverse Peer Review Decisions by Statute) F-1

Appendix G (California Code of Civil Procedure Section 1094.5) G-1

Appendix H (Medical Staff Bylaws of Mercy Hospital) H-1

Appendix I (California Administrative Code Mandating Peer Review) I-1

TABLE OF AUTHORITIES

Cases

Page

Aetna Life Insurance Co. v. Lavoie, 475 U.S. 813, 106 S.Ct. 1580, 89 L.Ed.2d 823 (1986) 25, 26

Anton v. San Antonio Community Hospital, 19 Cal.3d 802, 140 Cal.Rptr. 442 (1977) 11, 16, 19, 20, 21, 22, 23, 28

Ascherman v. St. Francis Memorial Hospital, 45 Cal.App.3d 507, 119 Cal.Rptr. 507 (1975) 16

Bixby v. Pierno, 4 Cal.3d 130, 93 Cal.Rptr. 234, 481 P.2d 242 (1971) 11

Blum v. Yaretsky, 457 U.S. 991, 102 S.Ct. 2777, 73 L.Ed.2d 534, (1982) 10

Board of Regents v. Roth, 408 U.S. 564, 92 S.Ct 2701, 33 L. Ed.2d 548 (1972) 15, 17, 18

Boddie v. Connecticut, 401 U.S. 371, 91 S.Ct. 780, 28 L.Ed.2d 113 (1971) 15

Briscoe v. Bock, 540 F.2d 392 (8th Cir. 1976) 7

Burton v. Wilmington Parking Authority, 365 U.S. 715, 81 S.Ct. 856, 6 L.Ed.2d 45 (1961) 9

Cipriotti v. Board of Directors, 147 Cal.App.3d 148, 196 Cal.Rptr. 367 (1983) 16

Connell v. Higginbotham, 403 U.S. 207 91 S.Ct. 1772, 29 L.Ed.2d 418 (1971) 17

Darlak v. Bobear, 814 F.2d 1055 (5th Cir. 1987) 11

Elam v. College Park Hospital, 132 Cal.App.3d 332, 183 Cal.Rptr. 156 (1982) 13

Edwards v. Fresno Community Hospital, 38 Cal.App.3d 702, 113 Cal.Rptr. 579 (1974) 12

Ezekial v. Winkley, 20 Cal.3d 267, 142 Cal.Rptr. 418, 572 P.2d 32 (1977) 16

Table of Authorities

Cases

Page

Ezpeleta v. Sisters of Mercy Health Corp., 800 F.2d 119 (7th Cir. 1986) 5

Garrow v. Elizabeth General Hospital and Dispensary, Inc., 79 N.J. 549, 401 A.2d 533 (1979) 20

Gill v. Mercy Hospital, 199 Cal.App.3d 889, 245 Cal.Rptr. 304 (1988) 1, 22

Goldberg v. Kelly, 397 U.S. 254, 90 S.Ct. 1011, 25 L.Ed.2d 287 (1970) 10, 17

Goss v. Lopez, 419 U.S. 565, 95 S.Ct. 729, 42 L.Ed.2d 725 (1975) 15, 17

Greco v. Orange Memorial Hospital Corp., 513 F.2d 873 (5th Cir. 1975) 7

Hodge v. Paoli Memorial Hospital, 576 F.2d 563 (3rd Cir. 1978) 7

Jackson v. Metropolitan Edison Co., 419 U.S. 345, 95 S.Ct. 449, 42 L.Ed.2d 477 (1974) 6

Lassiter v. Department of Social Services, 452 U.S. 18, 101 S.Ct. 2153, 68 L.Ed.2d 640 (1981) 11, 20

Lew v. Kona Hospital, 754 F.2d 1420 (9th Cir. 1985) 11

Loh-Seng Yo v. Cibola General Hospital, 706 F.2d 306 (10th Cir. 1983) 7

Lubin v. Crittenden Hosp. Assn., 713 F.2d 414 (8th Cir. 1983) 7

Madry v. Sorel, 558 F.2d 303, (5th Cir. 1977) 7

Marrese v. Interqual, Inc., 748 F.2d 373, (7th Cir. 1984) 5

Matthews v. Eldridge, 425 U.S. 319, 96 S.Ct. 893, 47 L.Ed.2d 18 (1976) 11

Morrissey v. Brewer, 408 U.S. 471, 92 S.Ct. 2593, 33 L.Ed.2d 484 (1972) 17

Musso v. Suriano, 586 F.2d 59 (7th Cir. 1978) 7

Table of Authorities

Cases

	Page
Parker v. Gladden, 385 U.S. 363, 87 S.Ct. 468 (1966)	26
Patrick v. Burget, ___ U.S. ___, 108 S.Ct. 1658, 100 L.Ed.2d 83 (1988)	3, 5, 6
Peterson v. Tucson General Hospital, Inc., 114 Arizona 66, 559 P.2d 186 (1976)	6
Pinsker v. Pacific Coast Soc. of Orthodontists, 1 Cal.3d 160, 81 Cal.Rptr. 623, 460 P.2d 495 (1969)	16
Rinaldi v. Yeagar, 384 U.S. 305, 86 S.Ct. 1497, 16 L.Ed.2d 577 (1966)	24
San Francisco Arts & Athletics v. Olympic Committee, __U.S.__, 107 S.Ct. 2971, 97 L.Ed.2d 427 (1987)	7
Sarin v. Samaritan Health Center, 813 F.2d 755 (6th Cir. 1987)	5, 7
Schlein v. Milford Hospital, Inc., 561 F.2d 427 (2nd Cir. 1977)	7
Shaw v. Hospital Authority of Cobb County, 507 F.2d 625 (5th Cir. 1975)	12
Silver v. Castle Memorial Hospital, 53 Hawaii 475, 497 P.2d 564 (1972)	6
Sniadach v. Family Finance Corporation, 395 U.S. 337, 89 S.Ct. 1820, 23 L.Ed.2d 349 (1969)	15
Storrs v. Lutheran Hospitals and Homes Society of America, Inc. Aiaska, 609 P.2d 24 (1980)	6
Strumsky v. San Diego County Employee Retirement Ass'n., 11 Cal.3d 28, 112 Cal.Rptr. 805, 520 P.2d 29 (1974)	11
Taylor v. St. Vincent's Hospital, 523 F.2d 75 (9th Cir. 1975)	7
Walters v. National Ass'n of Radiation Survivors, 473 U.S. 305, 105 S.Ct. 3180, 87 L.Ed.2d 220 (1985)	20

Table of Authorities

Cases

	Page
Watkins v. Mercy Hospital Center, 520 F.2d 894 (9th Cir. 1975)	7
Wieman v. Updegraff, 344 U.S. 183, 73 S.Ct. 215, 97 L.Ed. 216 (1952)	17
Wisconsin v. Constantineau, 400 U.S. 433, 91 S.Ct. 507, 27 L.Ed.2d 515 (1971)	17
Wolff v. McDonnell, 418 U.S. 539, 94 S.Ct. 2963, 41 L.Ed.2d 935 (1974)	17
Volpecelli v. Jared Sidney Torrance Memorial Hospital, 109 Cal.App.3d 242, 167 Cal.Rptr. 610 (1980)	12
Zobel v. Williams, 457 U.S. 55, 102 S.Ct. 2309, 72 L.Ed.2d 672 (1982)	23

TABLE OF AUTHORITIES

Statutes

Page

A. California

California Business and Professions Code
§ 805 ..... 2, 8, 12, 14, 18, 19
§ 805.5 ..... 2, 12, 14
§ 805.5(c) 9
California Civil Code, Sec. 43.7 9
California Code of Civil Procedure, Sec. 1094.5 .....
..... 2, 5, 13, 19, 21, 22, 23, 24
California Evidence Code
§ 1156 9
§ 1157 9

B. Federal

Health Care Quality Improvement Act of 1986, P.L. 99-660, 42 U.S.C. Sec. 11101 ..... 2, 13
28 U.S.C. Sec. 1257(3) 2
42 U.S.C. Sec. 1983 5

Other Authority Cited

California Administrative Code, Title 22, Sec. 70701(a)(1)(F) 8
California Administrative Code, Title 22, Sec. 70703(a) (1988) 8
California Rules of Court, Rule 28(f) 1
Purdy, "Physician Supply in California, 1983," XVI *Socioeconomic Report*, (California Medical Association, 1986) 2
83 Texas Medicine 91 (March, 1987) 3

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PETITION FOR WRIT OF CERTIORARI TO THE CALIFORNIA COURT OF APPEAL AND APPENDIX

I.

INTRODUCTION

The petitioner, Zora S. Gill, M.D., requests that a Writ of Certiorari issue to review the judgment and opinion of the California Court of Appeal entered on March 1, 1988.

1. Opinion Below.

The reported opinion of the California Court of Appeal, 5th Appellate District, *Gill v. Mercy Hospital*, 199 Cal.App.3d 889, 245 Cal.Rptr. 304 (1988), appears in the Appendix "A". The California Supreme Court, within its discretion pursuant to Rule 28(f) of the California Rules of Court, declined to grant a timely filed petition for review and issued no opinion.

2. Jurisdiction.

The California Supreme Court denied the Petition for Review on May 18, 1988 by an unreported order. This Petition for Writ of Certiorari is filed within 90 days of that date. This Court's jurisdiction is invoked under 28 U.S.C. § 1257(3).

3. Constitutional and Statutory Provisions.

This Petition involves the Due Process and Equal Protection clauses of the Fourteenth Amendment to the United States Constitution, Sections 805 and 805.5 of the California Business and Professions Code, Section 1094.5 of the California Code of Civil Procedure, and the Health Care Quality Improvement Act of 1986, Publ. L. 99-660, 100 Stat. 3784, 42 U.S.C. § 11101, et seq.

II.

STATEMENT OF THE CASE

The increasing oversupply of physicians in the United States and more particularly in California,[1] has caused a noted increase in the number of adversary hospital hearings regarding medical staff privileges.

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[1]"The number of physicians practicing in California continued to climb in 1983, the latest year for which statistics are available augmenting what many observers believe to be an existing oversupply of physicians in the state." Purdy, "Physician Supply in California", 1983, XVI, *Socioeconomic Report*, p. 1, (Calif. Medical Association, 1986). The report goes on to say that with the exception of ear, nose and throat specialists, "all other surgical specialties are oversupplied" and "the supply of physicians in California is more than 16% greater than recommended by [the Graduate Medical Education National Advisory Committee]." Needless to say, there is great incentive by physicians already on the medical staff of a hospital to limit competition by limiting or denying hospital privileges to other physicians.

As this court realized in *Patrick v. Burget*, ____ U.S. ____, 108 S.Ct. 1658, 100 L.Ed.2d 83 (1988), "peer review"[2] can be used by physicians for improper purposes. Such was the case here. Petitioner in a companion state proceeding seeking damages has alleged, *inter alia*, that certain physicians who are members of the medical staff of respondent hospital engaged in a conspiracy to drive him out of the practice of medicine in Bakersfield, California to interfere with his existing practice, and to interfere with the referral patterns of primary care physicians in referring patients needing surgery to petitioner.

The procedure upheld as "fair" by the Court of Appeal in this case has been characterized by the California Medical Association as:

> "A procedure which permits the prosecutor to select the evidence which it will divulge, determine whether legal representation will be permitted, shift the burden of proof, permit a witness for the prosecution to participate in the jury's deliberation, and limit judicial review to a search for substantial evidence supporting the verdict, is neither 'fair' nor reasonably calculated to determine the truth." Letter dated April 27, 1988 from the California Medical Association requesting that the California Supreme Court grant review of the Court of Appeal's decision in this case. See Appendix "B" for the full text of this letter.

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[2]Peer review has been broadly defined as "the physician evaluation of medical and health care services including the evaluation of the qualifications of physicians and of the quality of patient care rendered by those physicians". 83 *Texas Medicine* 91 (March, 1987). "Peer Review" for the purposes of this Petition means a formal system instituted in a hospital by which members of the hospital's medical staff form themselves into a committee that reviews the charges against a physician that he is not worthy of having medical staff privileges and then at the physician's sole request holds a hearing to determine whether or not these charges can be substantiated.

Petitioner Zora S. Gill, M.D., a physician duly licensed to practice medicine by the State of California's Bureau of Medical Quality Assurance, applied for and was granted, provisionally, medical staff privileges at respondent Mercy Hospital ("Hospital"). The local custom and practice was to have the surgery of a provisionally admitted medical staff member be monitored by other physicians for approximately 10 to 20 surgeries or for six months in order to evaluate his surgical skills. Prior to the Hospital administrative action complained of, Dr. Gill had enjoyed full staff privileges to do a broad spectrum of surgery, albeit, with monitors. Dr. Gill, who had performed approximately 100 surgeries prior to the Ad Hoc Committee's hearing, sought to be relieved of monitoring after two years. Rather than grant Dr. Gill's request, the Hospital filed charges against Dr. Gill signed by the Hospital Administrator Phyllis Hughes.

At the Ad Hoc Committee hearing, the "peer review" committee hearing, held to review the charges, Dr. Gill was denied his timely request that he be represented by counsel; he was denied a timely request for discovery of all the evidence that supported the charges made against him; he was required to carry a burden of proof unknown in the law "by an appropriate showing" to disprove the charges made against him; and an admittedly prejudiced and biased individual, the hospital administrator, Phyllis Hughes, who signed the charges against Dr. Gill, was present *ex parte* during the deliberations of the Ad Hoc Committee in rendering its decision following the hearing.

Dr. Gill appealed the adverse Ad Hoc Committee's decision to the Mercy Hospital Board of Directors, which affirmed the decision.

Dr. Gill filed a Petition for Writ of Mandate in the Kern County Superior Court, the statutory procedure applicable to effectuate judicial review. Pursuant to Section 1094.5 of

the California Code of Civil Procedure, Dr. Gill timely raised the additional issue that the difference between the judicial review provided between public and private hospitals in that statute violated the Equal Protection Clause.

The Superior Court judgment upholding the hospital's decision was appealed to the California Court of Appeal. That Court's opinion, after modification, was certified for publication. The Court of Appeal held California Code of Civil Procedure § 1094.5 constitutional, petitioner's rights to a fair proceeding not violated, and "[s]ubstantial evidence clearly supported the decisions of the hospital board, the ad hoc committee and the trial court in this case." 245 Cal.Rptr. at 308. Thereafter, Dr. Gill sought a review of the Court of Appeal's decision by the California Supreme Court; the petition for review was denied. Petitioner has filed a timely Petition for Writ of Certiorari with this Court.

III.

REASONS FOR GRANTING THE WRIT

A. California's Statutorily Mandated Physician "Peer Review" Constitutes the Fourteenth Amendment "State Action".

What was not raised or decided in this Court's recent decision in *Patrick v. Burget, supra,* was whether statutory schemes regulating peer review constitutes "state action" for purposes of the Fourteenth Amendment.[3] This Court held that Oregon's statutory scheme was not "state action"

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[3]The decided cases hold that the tests for anti-trust "state action" differ from Fourteenth Amendment "state actions". *Marrese v. Interqual, Inc.,* 748 F.2d 373, 395, fn. 25 (7th Cir. 1984); *Ezpeleta v. Sisters of Mercy Health Corp.,* 800 F.2d 119, 122 (7th Cir. 1986). The court in *Sarin v. Samaritan Health Center,* 813 F.2d 755 (6th Cir. 1987) followed *Ezpeleta* in finding "state action" for anti-trust but found the same regulations were not "state action" to support an allegation for a violation of 42 U.S.C. § 1983.

for the purpose of exemption from federal anti-trust laws because Oregon did not exercise active supervision over the challenged anti-competitive conduct. "The requirement [of active supervision] is designed to ensure that the state action doctrine will shelter only the particular *anticompetitive acts* of private parties that, in the judgment of the State, actually further state regulatory policies." 108 S.Ct. at 1663 (emphasis added). Implicit in this Court's decision was that Oregon did not enact statutes governing and encouraging peer review proceedings to regulate competition between physicians but rather to ensure, to the greatest extent possible, that incompetent physicians would not have medical staff privileges. It was clearly Oregon's intent that peer review be performed in good faith and not in bad faith for anti-competitive purposes as was done by the respondents in *Patrick*. Oregon's legislative actions were concerned with competence, not competitiveness.

The question presented by this Petition is whether a statutory scheme enacted by California to ensure competency of physicians which necessarily involves the participation of hospitals and their medical staffs constitutes Fourteenth Amendment "state action." This is a question of first impression for this Court.

Petitioner is not asking this Court to decide that the provision of public funding with its attendant system of extensive regulation or whether the state licensing of hospitals and physicians[4] is "a sufficiently close nexus between

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[4]The following state courts have concluded that physicians should be accorded procedural due process because the funding has rendered the hospitals "quasi-public": *Storrs v. Lutheran Hospitals and Homes Society of America, Inc.*, Alaska, 609 P.2d 24 (1980); *Peterson v. Tucson General Hospital, Inc.*, 114 Ariz. 66, 559 P.2d 186 (1976); *Silver v. Castle Memorial Hospital*, 53 Haw. 475, 497 P.2d 564 (1972), *cert. denied*, 409 U.S. 1131, 93 S.Ct. 936, 35 L.Ed.2d 264 (1973).

Nearly every circuit court of appeals since *Jackson v. Metropolitan Edison Co.*, 419 U.S. 345, 95 S.Ct. 449, 42 L.Ed.2d 477 (1974) has

the challenged action of the Hospital [peer review] and the state's regulation so that the action of the former may be fairly treated as that of the state itself." *Lubin v. Crittenden Hosp. Assn.*, 713 F.2d 414, 415 (8th Cir. 1983). Petitioner concedes that those particular forms of state regulation are not sufficiently related to peer review for a finding of "state action." Petitioner also acknowledges that a state or the federal government "may subsidize private entities without assuming constitutional responsibility for their actions." *San Francisco Arts & Athletics v. Olympic Committee*, ___ U.S. ___, 107 S.Ct. 2971, 2985, 97 L.Ed.2d 427 (1987).

Instead, Petitioner is asking this Court to consider California's statutorily created system of peer review and to decide whether peer review proceedings held pursuant to these statutes constitute Fourteenth Amendment "state action". The California Legislature in enacting its most recent amendments to the statutes regulating peer review stated that the legislative purpose of such legislation was "to further *integrate private and public systems* of peer review in the provision of health services." 1987 Cal. Stats. c. 1044, § 1 (Emphasis added). The integration of these two systems accomplishes California's legislature purpose of trying to maximize the adequacy and quality of medical care provided to hospital patients by weeding out incompetent physicians through denying or restricting medical staff privileges.

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decided that question differently: see, *Schlein v. Milford Hospital, Inc.*, 561 F.2d 427 (2nd Cir. 1977); *Hodge v. Paoli Memorial Hospital*, 576 F.2d 563 (3rd Cir. 1978); *Greco v. Orange Memorial Hospital Corp.*, 513 F.2d 873 (5th Cir. 1975); *Madry v. Sorel*, 558 F.2d 303 (5th Cir. 1977), *cert. denied*, 434 U.S. 1086 (1978); *Sarin v. Samaritan Health Center*, 813 F.2d 755 (6th Cir. 1987); *Musso v. Suriano*, 586 F.2d 59 (7th Cir. 1978), *cert. denied*, 440 U.S. 971 (1979); *Briscoe v. Bock*, 540 F.2d 392 (8th Cir. 1976); *Watkins v. Mercy Hospital Center*, 520 F.2d 894 (9th Cir. 1975); *Taylor v. St. Vincent's Hospital*, 523 F.2d 75 (9th Cir. 1975), *cert. denied*, 424 U.S. 948 (1976); *Loh-Seng Yo v. Cibola General Hospital*, 706 F.2d 306 (10th Cir. 1983).

The public system of peer review involves the licensing of physicians by California's administrative licensing agency, the Bureau of Medical Quality Assurance, and investigations into whether a physician should continue to hold a license based upon complaints filed by the public or by the filing of reports of adverse peer review proceedings undertaken by hospitals and/or their medical staffs (part of the "private" system).

To ensure that there is a private system of peer review, California's administrative regulations require that every "hospital shall have an organized medical staff responsible to the governing body for the adequacy and quality of the medical care rendered to patients in the hospital." Cal. Administrative Code, Title 22, § 70703(a) (1988).[5] According to Title 22, California Administrative Code, § 70701(a)(1)(F), a hospital must have a governing body which must adopt written bylaws in accordance with legal requirement and its community responsibility which shall include "[s]elf-government by the medical staff with respect to the professional work performed in the hospital . . . ." The governing body shall "[a]ssure that medical staff bylaws, rules and regulations are subject to governing body approval . . . [and] . . . these bylaws shall include an effective formal means for the medical staff, as a liaison, to participate in the development of all hospital policy". *Id.* at (8), (9). When a health care facility terminates, restricts or denies the medical staff privileges of a physician, it must promptly report to the Bureau of Medical Quality Assurance all facts and circumstances that cause such decision to be taken, California Business and Professions Code 805 et seq. California Code of Civil Procedure § 1094.5 provides for judicial review of all peer review proceeding decisions taken by California hospitals to determine whether they

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[5]Nine other states also mandate peer review. See Appendix "C" for the text of such provisions.

were made in good faith pursuant to fair procedure and were supported by facts. California statutes further provide that all peer review proceedings are confidential in malpractice actions, California Evidence Code §§ 1156 and 1157, and provides for immunity to participants in the peer review process, California Civil Code § 43.7.

Most importantly, the State of California has inserted itself in the "private" system of peer review: all hospitals pursuant to section 805.5 of the California Business and Professions Code must seek copies of all reports of adverse peer review proceedings every time a physician either seeks reappointment to the hospital's medical staff or initially applies for medical staff privileges. Failure to do so is a crime, California Business and Professions Code, § 805.5(c), Appendix "E". This dissemination of adverse results of peer review proceeding prevents a physician who has had his medical staff privileges denied or restricted at one hospital from moving to a different part of the state where he is unknown and applying for medical staff privileges at a hospital which would be unaware of this restriction or denial. The "805 Report" follows the physician everywhere regardless of whether the adverse results were achieved at a "fair hearing" or not.

This integration of public and private systems of peer review meets the "symbiotic relationship" test set forth in *Burton v. Wilmington Parking Authority*, 365 U.S. 715, 81 S.Ct. 856, 6 L.Ed.2d 45 (1961) because California could not realize its goal of weeding out incompetent physicians without participation of hospitals and/or their medical staffs in peer review proceedings. California could have, but chose not to, implement a system of peer review that was conducted by a governmental agency or an organization such as the California Medical Association which would come into a hospital setting to review its files concerning a physician who had been accused of incompetency by a member of the public, a member of the hospital's staff, and/or by a member

of the hospital's medical staff. Such a system would have been more costly and less efficient. Instead, California chose to make hospitals and their medical staff joint participants with it by giving them primary responsibility in ensuring that incompetent physicians do not have medical staff privileges.

Clearly, California "has exercised coercive power or has provided such significant encouragement, either overt or covert" by its statutory scheme to require a private system of peer review and integrating it into the public system of peer review that the conduct of peer review proceedings by hospitals and their medical staffs "must in law be deemed to be that of the State." *Blum v. Yaretsky*, 457 U.S. 991, 1004, 102 S.Ct. 2777, 2786, 73 L.Ed.2d 534 (1982).

B. Due Process Entitles a Physician to Be Represented by Retained Counsel at "Peer Review" Hearings Affecting a Physician's Ability to Practice Medicine.

Neither the California judicial system nor the California Legislature has recognized the right of a physician to be represented by a retained lawyer at peer review proceedings where an adverse determination can have dire consequences to a physician. This Petition seeks this Court's determination that such a right exists under the Federal Constitution. This Court has not previously addressed this issue.

This Court has recognized that elementary notions of fairness dictate that an individual be represented by counsel at a hearing in which he might be deprived of a fundamental property interest. In *Goldberg v. Kelly*, 397 U.S. 254, 90 S.Ct. 1011, 25 L.Ed.2d 287 (1970), this Court determined that welfare recipients who faced a hearing at which their benefits were to be terminated were entitled to be represented by retained counsel. Since *Goldberg,* most of the cases concerning due process and the right to counsel in non-criminal cases have dealt with requests for *appointed* counsel, as distinguished from *retained* counsel. Regarding

appointed counsel, this Court has held that three factors are to be taken into account. These are: the private interest at stake, the governmental interest at stake, and the risk that the procedures used will lead to erroneous decisions. This Court has held that these factors are to be balanced against each other, and their net weight is set against the presumption that there is no right to appointed counsel, implying, necessarily, a right to retained counsel. This Court has held that the right to counsel in such instances is of such importance that the government must provide counsel at its expense if the party cannot afford retained counsel. See *Lassiter v. Department of Social Services*, 452 U.S. 18, 101 S.Ct. 2153, 68 L.Ed.2d 640 (1981); *Matthews v. Eldridge*, 425 U.S. 319, 96 S.Ct. 893, 47 L.Ed.2d 18 (1976). If the tests for a right to a*ppointed* counsel are met, *a fortiori, retained* counsel should not be excluded from peer review proceedings.

1. A California Physician Has A Property Interest In Obtaining Full Medical Staff Privileges.

California courts[6] and some of the circuit courts[7] recognize that Petitioner has a property interest in obtaining full

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[6] *Anton v. San Antonio Community Hospital*, 19 Cal.3d 802, 140 Cal.Rptr. 442 (1977); *Strumsky v. San Diego County Employee Retirement Ass'n.*, 11 Cal.3d 28, 112 Cal.Rptr. 805, 520 P.2d 29 (1974); *Bixby v. Pierno*, 4 Cal.3d 130, 93 Cal.Rptr. 234, 481 P.2d 242 (1971).

[7] "It is well settled in this circuit [Fifth] that a physician's staff privileges may constitute a property interest protected by the due process clause of the Fourteenth Amendment.

* * *

"We think that the Charity regulations providing for a hearing prior to the suspension or termination of staff privileges implies that such privileges will be suspended or terminated only for cause, and that therefore such privileges constitute a property interest protected by the Fourteenth Amendment." *Darlak v. Bobear*, 814 F.2d 1055, 1061-1062, 1072 (5th Cir. 1987). See also *Lev v. Kona Hospital*, 754 F.2d 1420, 1424

medical staff privileges at Hospital and at hospitals other than at Hospital where petitioner enjoys or desires to apply for medical staff privileges. In *Volpecelli v. Jared Sidney Torrance Memorial Hospital,* 109 Cal.App.3d 242, 167 Cal.Rptr. 610 (1980), the court noted:

> "It is a generally accepted principle that a hospital's refusal to permit a physician to conduct his practice in hospital, as a practical matter, may well have the effect of denying him the right to capably practice his profession." 109 Cal.App.3d at 248; *Edwards v. Fresno Community Hospital,* 38 Cal.App.3d 702, 705, 113 Cal.Rptr. 579 (1974).

Medical staff privileges are crucial to a surgeon such as petitioner; a surgeon without medical staff privileges at any hospital would be limited to performing in-office procedures.

Under California law, any physician peer review proceedings that involve a denial or restriction of medical staff privileges must be reported to the Board of Medical Quality Assurance, the California licensing agency for physicians ("Section 805 Reports"). See California Business and Professions Code Section 805, printed in the Appendix "D". Additionally, whenever a physician seeks to renew his medical staff privileges at a hospital where he enjoys them or seeks medical staff privileges at another hospital, California law requires that this hospital contact the Board of Medical Quality Assurance for a report of whether or not the physician's medical staff privileges have been denied or restricted at any other hospital. See California Business and Professions Code Section 805.5, printed in the Appendix "E". All hospitals considering granting or renewing medical staff privileges use these Section 805 Reports[8] to

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(9th Cir. 1985); *Shaw v. Hospital Authority of Cobb County,* 507 F.2d 625 (5th Cir. 1975).

[8]As Section 805 of the California Business and Professions Code provides absolute immunity for all Section 305 Reports, even those

evaluate the application before them in making their decisions regarding medical staff privileges (Calif. Bus. & Prof. Code § 2282 requires medical staff appointments to be made an annual or biannual basis). Indeed, California law requires that hospitals have a duty to monitor the quality of their staffs and the failure to do so may be negligence. See *Elam v. College Park Hospital,* 132 Cal.App.3d 332, 183 Cal.Rptr. 156, 164-166 (1982). Hospitals, understandably, are reluctant to admit to staff membership any physician who has been denied staff membership at another hospital.

As a result of these statutory provisions, an adverse decision in a peer review proceeding has a domino effect on a physician's ability to maintain and obtain medical staff privileges elsewhere in the State of California.

Until 1986, the adverse effects of a peer review decision restricting or denying medical staff privileges of a California physician could be confined to the State of California. This limitation as to damage was eliminated when Congress enacted the Health Care Quality Improvement Act of 1986, P.L. 99-660, 42 U.S.C. § 11101 et seq. (hereinafter referred to as "HCQIA") recognizing "a national need to restrict the ability of incompetent physicians to move from State to State without disclosure or discovery of the physician's previous damaging or incompetent performance." (§ 11101). HCQIA established a procedure by which the results of certain peer review proceedings would be reported to a central clearing house (§ 11133) and imposed a duty upon hospitals to obtain such reported information whenever a physician applies for medical staff privileges and every 2 years thereafter (§ 11135). These reports which are

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containing false and/or misleading information, the potential for abuse and vindictiveness by the use of the peer review process by a physician's competitors or others is obvious and it is clear that the legislative reporting structure prejudices Petitioner's personal and property rights.

filed with a national clearing house are generally referred to as Section 423 reports.

The reporting system required by HCQIA is similar to that established by the California Business and Professions Code §§ 805 and 805.5[9] with HCQIA's primary difference being that it is national in scope. The legislative history of HCQIA reveals that Congress was aware of the impact of this reporting system on the physicians and the necessity that "physicians receive fair and unbiased review to protect their reputations and medical practices". H.R. Report No. 99-903, p. 11, reprinted in 1986, U.S. Code Cong. and Adm. News, p. 6287, 6393. Congress felt that one way of protecting physicians' reputations and medical practices would be if they were afforded procedural due process in peer review proceedings. Congress thus declared that due process requirements would be deemed to have been satisfied if, *inter alia*, physicians affected by a peer review proceeding were granted the right "to representation by an attorney . . . . " at a peer review proceeding (§ 11112(b)(3)(C)(i)).

In 42 U.S.C. § 11111(c), Congress made these requirements concerning the provision of due process applicable to all states after October 14, 1989 unless a state by legislation specifically elects to opt out of such provision. It is clear from the legislative history of HCQIA that if any state elected to opt out of the specific provisions contained in HCQIA as to due process rights to be afforded to affected physicians that such state must have similar guarantees of due process. Congress declared "if other procedures are followed but are not precisely of the character spelled out in subsection 102(b) [42 U.S.C. § 11112(b)], the test of 'adequacy' may still be met under other prevailing law." The Committee on Energy and Commerce, H.R. No. 903, 99th

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[9]Forty-four states have reporting requirement of adverse peer review decisions similar to California's Business and Professions Code § 805. See Appendix "F" for the text of such statutes.

Cong. 2d Sess. 6, reprinted in 1986 U.S. Cong. and Admin. News 6384, 6393.

Despite the congressionally declared intention that the procedural due process set forth in HCQIA or some substantially equivalent procedure be applied to all physicians affected by peer review proceedings, the California Court of Appeal below held: "A review of the act satisfies us that it was not the intent of Congress to modify existing California peer review hearing procedures." 249 Cal.Rptr. at 313.

The enactment of HCQIA affects California physicians nationally because an adverse decision in a peer review hearing at one hospital in California can have a nationwide impact on a physician's ability to practice medicine anywhere in the United States by virtue of the nationwide reporting and dissemination requirements of HCQIA.

Therefore, the interest of the petitioner is high. This court has indicated that in determining whether due process applies, it is necessary to look to the *nature* of the interests at stake, not the weight. *Goss v. Lopez*, 419 U.S. 565, 575-76, 95 S.Ct. 729, 42 L.Ed.2d 725 (1975); *Board of Regents v. Roth*, 408 U.S. 564, 92 S.Ct. 2701, 33 L.Ed.2d 548 (1972). In *Goss* the court held that a ten (10) day suspension from public school was sufficiently important interest to require due process. Similarly, this court has held that if there is a deprivation of property, then the Due Process Clause would apply. See *Sniadach v. Family Finance Corporation*, 395 U.S. 337, 342, 89 S.Ct. 1820, 23 L.Ed.2d 349 (1969); *Boddie v. Connecticut*, 401 U.S. 371, 378-79, 91 S.Ct. 780, 28 L.Ed.2d 113 (1971); *Board of Regents v. Roth, supra,* at 570 note 8, 33 L.Ed.2d 548. The court held in *Goss, supra*, that a ten day suspension from school is not *de minimis* "and may not be imposed in complete disregard of the Due Process Clause". *Goss v. Lopez*, 419 U.S. at 576. It is important to point out that in *Goss* the court stopped short of providing an absolute right to counsel but held that the school discipli-

narian should exercise his discretion in making that determination.

2. A Peer Review Hearing Is Adversarial In Nature.

A California hospital admission or disciplinary hearing is an evidentiary and adversary hearing in which the California courts have held that a physician is entitled to notice of the charges, the right to call and confront witnesses, the right to inspect in advance relevant charts, documents and other written material which will be used against him, and to introduce similar physical evidence. Such a hearing is presided over by a hearing officer and is recorded by an official court reporter. The hospital designates a staff physician to present the charges. California courts have continuously recognized that a physician's right to practice medicine and his access to membership in medical staffs and in medical societies is "a practical prerequisite to pursuit of a medical or dental specialty" and as such is protected by due process and fair procedures. See, *e.g.*, *Ezekial v. Winkley*, 20 Cal.3d 267, 271, 142 Cal.Rptr. 418, 572 P.2d 32, (1977); *Anton v. San Antonio Community Hospital*, 19 Cal.3d 802, 140 Cal.Rptr. 442 (1977); *Pinsker v. Pacific Coast Soc. of Orthodontists*, 1 Cal.3d 160, 166, 81 Cal.Rptr. 623, 460 P.2d 495 (1969); *Ascherman v. St. Francis Memorial Hospital*, 45 Cal.App.3d 507, 511-12, 119 Cal.Rptr. 507 (1975).[10]

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[10]Although the California courts have recognized such rights and significant interests involved, they have nonetheless held the physician, without benefit of legal counsel, to a standard of creating a proper record, recording proper objection, making timely challenges in a form required of skilled advocates, lawyers. See, for example, *Anton v. San Antonio Community Hospital*, 19 Cal.3d 802, 827, 140 Cal.Rptr. 442, 456-57 (1977); *Cipriotti v. Board of Directors*, 147 Cal.App.3d 148, 156-57, 196 Cal.Rptr. 367, 373-74 (1983).

3. The Due Process Clause Requires Procedural Protection At A Peer Review Hearing.

Under California law, a physician has a protected right to a hearing with all its attendant features, notice, and an opportunity to be heard. This court has held that once a person has a legitimate claim to a state right he may demand the procedural protections of due process. This applies to continued employment, *Connell v. Higginbotham*, 403 U.S. 207, 91 S.Ct. 1772, 29 L.Ed.2d 418 (1971); *Wieman v. Updegraff*, 344 U.S. 183, 191-192, 73 S.Ct. 215, 97 L.Ed. 216 (1952), welfare benefits; *Goldberg v. Kelley, supra*, parole revocation; *Morrissey v. Brewer*, 408 U.S. 471, 92 S.Ct 2593, 33 L.Ed.2d 484 (1972), prison good time credits; *Wolff v. McDonnell*, 418 U.S. 539, 94 S.Ct. 2963, 41 L.Ed.2d 935 (1974) and even the right to one's "good name, reputation, honor or integrity"; *Wisconsin v. Constantineau*, 400 U.S. 433, 437, 91 S.Ct. 507, 27 L.Ed.2d 515 (1971); *Board of Regents v. Roth*, 408 U.S. 564, 573, 92 S.Ct. 2701, 33 L.Ed.2d 548 (1972).

The "805 report" mandated by the State of California is more devastating to a physician than the "report" regarding drunkenness disseminated in *Wisconsin v. Constantineau, supra*. There this Court held that a statute which enabled a local police chief to post a notice in all retail liquor outlets banning sales of liquor to Ms. Constantineau violated due process because information was disseminated by state actors with no notice to Mrs. Constantineau. The Court held that "[w]here a person's good name, reputation, honor or integrity is at stake because of what the government is doing to him, notice and an opportunity to be heard are essential." 400 U.S. at 437, 91 S.Ct. at 510. Similarly, in *Goss v. Lopez, supra,* the Court held that even a ten day suspension for public school "could seriously damage the student's standing with their fellow pupils and their teachers as well as interfere with later opportunities for higher education." 419 U.S. at 575, 95 S.Ct. at 736. The *Goss*

majority noted that four of twelve randomly selected Ohio colleges specifically inquire about high school suspension on this respective applications. 419 U.S. at 575 n. 1, 95 S.Ct. at 736, n. 7. This court made clear in *Board of Regents v. Roth, supra,* that if a decision denying continued employment "imposed on him a stigma or other disability that foreclosed his freedom to take advantage of other employment opportunities", this would violate due process. 408 U.S. at 573, 92 S.Ct. at 2707, and cases cited therein. Each of these elements of due process, a property interest, good name and reputation, foreclosed employment and the possibility of stigma, are here implicated.

The operation of California law, however, does, in this context, impose a stigma on petitioner's good name, honor, reputation and integrity which "forecloses his freedom to take advantage of other employment opportunities" and "seriously damages" his standing in the eyes of "his peers" and other hospital staff.

The economic effect of the reporting and dissemination provisions of California's Business and Professions Code Sections 805 and 805.5 and HCQIA mean that a doctor who seeks to join a hospital or medical staff, "a practical prerequisite to a medical specialty", runs the risk that a denial or a restriction on full medical staff privileges will be investigated by the Board of Medical Quality Assurance which issues him his license, any hospital where he presently enjoys membership which issues him a pay check or allows him to admit patients, and/or by any hospital where he applies for medical staff privileges.

In addition, every hospital staff application requests information concerning denial of membership. So a hospital may violating due process deny or restrict membership and create the whipsaw effect on a doctor's good name, reputation, future employment opportunities, in effect stigmatize a physician for life.

This court should grant the writ because this case raises a serious question concerning the impact of a denial of full medical staff privileges on a physician. This case raises issues as important as those which affect high school attendance, welfare benefits, the application of parole, good time credits, and the right to pursue employment with one's good name and reputation intact.

4. The Interests Of The State.

The second prong of the due process test is to look at the interest of the state. While the state is not a party appearing in this action or any similar action involving physicians, it has expressed its interest and involvement by passing California Business and Professions Code § 805 et seq. Through this legislation the State of California has indicated that it considers the peer review procedure essential to weeding out incompetent physicians. By providing for judicial review of peer review decisions by enacting California Code of Civil Procedure § 1094.5, California has demonstrated an interest in decisions which were obtained by fair procedure and can be factually substantiated.

California's comprehensive regulatory scheme does not oppose the presence of a doctor's attorney at hearings affecting a physician's ability to practice medicine. Where the proceeding directly affects the license of a physician, it grants such right to doctors against whom the Board of Medical Quality Assurance brings an action to suspend or revoke a license. California courts do not prevent a physician from having retained counsel at a peer review proceeding, however, the California Supreme Court has held that a provision of a hospital bylaw which permitted a hospital judicial review committee, composed entirely of other physicians, the discretion to deny a physician the right to have retained counsel was valid. *Anton v. San Antonio Community Hospital*, 19 Cal.3d 802, 140 Cal.Rptr. 442 (1977).

The California view is not shared by other states. The New Jersey Supreme Court, in a decision made subsequent to *Anton*, has permitted representation by retained counsel at private hospital hearings when it was clear that unlike the facts in *Anton, supra,* the affected physician requested the right to be represented by counsel prior to the commencement of the peer review hearing and did so unequivocally. *Garrow v. Elizabeth General Hospital and Dispensary, Inc.,* 79 N.J. 549, 401 A.2d 533 (1979). That court recognized the important role that counsel may be called upon to perform:

> "[T]he attorney, in addition to being in a position to advise the client during the hearing, will have the opportunity to present evidence on his behalf, to meet and explain adverse data and to present argument to the board. In view of the physician's substantial interest in proceedings of this nature, on balance, we believe that the physician should have the right to have counsel present at mandated hospital hearings. . . ." 79 N.J. at 566.

5. The Possibility Of An Erroneous Decision.

Neither Petitioner here nor respondents Hospital and Medical Staff are in a good position to supply the kind of data relating to the possibility of an erroneous decision supplied in either *Walters v. National Ass'n of Radiation Survivors,* 473 U.S. 305, 105 S.Ct. 3180, 3193, 87 L.Ed.2d 220 (1985) or *Lassiter, supra.* However, "procedural due process rules are shaped by the risk of error inherent in the truth finding process as applied to the generality of cases, not the rare exceptions." However, the *Walters* majority noted that if the nature of the proceeding is adversarial (involving some form of adversary, either lawyer or non-lawyer), and the burden of proof is on the party denied counsel, due process may require counsel. 105 S.Ct. at 3189.

Justice William Clark is in his dissent to the *Anton* majority opinion recognized that if the peer review proceed-

ing is required to be a "semi-judicial proceeding", it is appropriate to have retained counsel present by pointing out the inconsistency of the majority's holding that "on the one hand that plaintiff's rights are of such importance that decisions affecting them necessarily involve an exercise of judicial power [citation to the majority's decision] and on the other, that it is entirely proper to exclude attorneys from the presentation of evidence in this judicial proceeding [citation to the majority's decision]", 19 Cal.3d at 834.

Thus, the adversarial nature of the proceeding in which a medical representative prosecutes the hospital and medical staff's position, taken together with the allocation of the burden of proof to petitioner, tip the balance and result in a violation of due process.

Counsel is required to assist a physician in meeting the burden of proof, objecting to evidence by his adversary, and making legal and factual arguments that the physicial has satisfied his burden of proof.

C. California Code of Civil Procedure Section 1094.5 Violates the Equal Protection Clause in Providing for a Less Stringent Standard of Judicial Review of Decisions Taken by Private Hospitals than Those Taken by Public Hospitals

Section 1094.5 of the California Code of Civil Procedure provides for two different standards of review of peer review decisions, "independent judgment on the evidence" or "substantial evidence", depending upon whether the decision was taken by a public hospital or by a private hospital, respectively. Following a judicial declaration that decisions of private hospitals were to be reviewed by the same standard as those of public hospitals, *Anton, supra,* 19 Cal.3d at

815, California Code of Civil Procedure § 1094.5[11] was amended to provide as follows:

> "(d) Notwithstanding the provisions of subdivision (c) in cases arising from private hospital boards, abuse of discretion is established if the court determines that the finding are not supported by substantial evidence in the light of the whole record."

This statute was construed in *Anton v. San Antonio Community Hospital,* 132 Cal.App.3d 638, 183 Cal.Rptr. 423 (1982) ("*Anton II*") by the California Court of Appeal which ruled that the statute did not violate the equal protection clause of either the federal or California constitutions. The court's reasoning was not well-founded: the Court of Appeal conceded that there was little procedural distinction in peer review hearings between a private and a public hospital, but that there was a distinction as to the source for such requirements *viz*, the common law versus the Constitution. The court reasoned that if there was a due process distinction that could be made by the Legislature and courts, there could be an equal protection distinction. 132 Cal.App.3d at 656. The court whose decision is at issue here pointed out that: "Essentially there is no real difference between fair procedure and due process rights." *Gill v. Mercy Hospital*, 199 Cal.App.3d 889, 245 Cal.Rptr. 304, 312 (1988). In other words, the same procedural rights should be afforded a physician in a peer review proceeding whether such proceeding takes place in a private hospital or a public hospital.

The *Anton II* court, however, then proceeded to define one "highly significant, specific difference [between private and public hospitals in that public hospitals had] . . . subpoena power [citation omitted] and are therefore in a much better

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[11]The full text of the applicable portions of California Code of Civil Procedure are printed in Appendix "G".

position to obtain and present the facts than are private hospitals which do not enjoy subpoena power". *Supra*, 132 Cal.App.3d at 656. This distinction seems to require the opposite result. Without subpoena power the hearing is less likely to be reliable in terms of fact finding. Thus, it seems the reviewing court ought to look at such a determination with greater and stricter scrutiny rather than less stringent scrutiny. If the hearing is to be identical procedurally, irrespective of the sources of the requirement, it makes little sense that the method of judicial review be different. The purpose of the judicial review in each case of decisions arising out of public hospitals and private hospitals is the same: a rational and fair determination of the controversy. How can this be done consistently if the standard for judicial review is different? What *Anton II* permits is a system which says the hearing should be fair, irrespective of whether it is a public or private hospital, but, if it is not fair, only the public hospital cases will be fairly and adequately reviewed on appeal to the courts by writs of mandate as provided for in § 1094.5 of the California Code of Civil Procedure.

When a state provides for different treatment for different classes of individuals or institutions, "the distinctions it makes are subject to scrutiny under the Equal Protection Clause of the Fourteenth Amendment. Generally, a law will survive that scrutiny if the distinction it makes rationally furthers a legitimate state purpose." *Zobel v. Williams*, 457 U.S. 55, 61, 102 S.Ct. 2309, 2312-13, 72 L.Ed.2d 672 (1982). While public and private hospitals are admittedly financed differently, the purpose of peer review in both types of institutions is to ensure that only competent physicians are members of the medical staff. California's interest is that decisions taken by private and public hospitals be fair. As shown by the discussion undertaken by the *Anton II* court to justify its upholding CCP § 1094.5 against an equal protection challenge, the distinction made by the California State

Legislature is not rational. If anything, the standards of judicial review should be reversed so that the decisions taken by the institution with the least procedural safeguards would be subject to the stricter rather than the less stringent standard of judicial review.

Nor does the distinction between decisions arising from public hospitals and from private hospitals meet the Equal Protection Clause requirement set forth in *Rinaldi v. Yeagar,* 384 U.S. 305, 309, 86 S.Ct. 1497, 1500, 16 L.Ed.2d 577 (1966) that "the distinctions that are drawn have 'some relevance to the purpose for which the classification is made.' " The method of financing has no relevance as to the fairness of the procedure followed at the peer review hearing nor as to whether the decision taken can be supported by the facts presented at the peer review hearing.

Section 1094.5 of the California Code of Civil Procedure cannot survive even the least rigorous of Equal Protection scrutiny.

D. The Presence and Participation, Ex Parte, of the Charging Party, the Prosecutor, in the Deliberations of the Ad Hoc Committee Violates Due Process.

Ms. Hughes is the Hospital Administrator. Ms. Hughes participated in the investigation and preparation of the case against Dr. Gill that was presented at the Ad Hoc Committee hearing. Ms. Hughes was the sole signatory of the charges against Dr. Gill. Ms. Hughes' work product resulted in the only specific finding of incompetence and surgical misjudgment against Dr. Gill. As the record below indicates, she was not only present at the hearing, but participated in the deliberations of the Ad Hoc Committee in rendering its decision although she was not designated as a decision maker. Dr. Gill was excluded from the Ad Hoc Committee's deliberations. All the doctors who were members of the Ad Hoc Committee are subject to Ms. Hughes' administrative power and, therefore, would be disinclined to

go against her articulated position that Dr. Gill should not be given full medical staff privileges. It is quite clear that biased decision makers cannot be part of a hospital's judicial process. The question presented for this Court is whether Ms. Hughes' actions and her position as hospital administrator could have had such an influence on the actual decision makers as to taint the proceedings of the Ad Hoc Committee so that Dr. Gill's Fourteenth Amendment due process rights were violated.

This Court in *Aetna Life Insurance Co. v. Lavoie*, 475 U.S. 813, 106 S.Ct. 1580, 89 L.Ed.2d 823 (1986) held that the participation of one judge of a nine judge court who had a substantial interest in the outcome of the case before the Alabama Supreme Court in ruling on that case violated the Fourteenth Amendment's due process clause. The opinion of the court found significant that "... Justice Embry's vote was decisive in the 5-to-4 decision and he was the author of the court's opinion." 106 S.Ct. at 1588-1589. However, the concurring opinion of Justice Blackman, joined in by Justice Marshall, points out that the record of the case does not support the Court's assertion that Justice Embry's was the "decisive" vote but rather indicates that as initially Justice Embry was to write the minority opinion, perhaps it was his authoring of a forceful dissent that changed the vote of a colleague, given the dynamics well-known to his fellow justices of the shaping of a decision in any particular case. Justice Blackman in concluding that even if Justice Embry had not written the court's opinion, his very "participation in the case would have violated the Due Process Clause," pointing out that "[i]t makes little sense to intimate that if Justice Embry's dissent had led two colleagues to switch their votes, and the final vote had been 6-3, Aetna would somehow not have been injured by his participation." 106 S.Ct. at 1591.

In the context of a criminal trial, this Court has held that the comments of an authority figure such as a court bailiff

about the merits of the case to one or more members of the jury results in a proceeding "inherently lacking in due process." *Parker v. Gladden*, 385 U.S. 363, 365, 87 S.Ct. 468, 471 (1966). Both *Aetna* and *Parker* concern themselves with the possible violation of due process presented when influences are brought to bear on decision-makers, whether fellow judges or members of a jury, by someone of authority. Ms. Hughes was known to the members of the Ad Hoc Committee, the decision-makers in the instant case, to support the Medical Staff Executive Committee's recommendation that full medical staff privileges be denied Dr. Gill: they knew that she had signed the charges against Dr. Gill and had helped prepare the case against him. Ms. Hughes' hearsay statements adverse to Dr. Gill were admitted in evidence. The members of the Ad Hoc Committee also knew that as hospital administrator, Ms. Hughes had a great deal of influence over their own medical staff privileges as well as lesser matters of concern to them such as the scheduling of surgeries and the provision of particular nurses to assist in surgeries.

The bailiff in *Parker* did not sit in on the jury deliberations as did Ms. Hughes, yet his remarks which were heard by one or possibly more jurors were held sufficient to violate the defendant's due process rights to a fair trial. Ms. Hughes' presence during the Ad Hoc Committee decision-making deliberations can be likened to a chief of police sitting in on jury deliberations when the jury consists entirely of police officers.

Although Ms. Hughes was not herself a member of the Ad Hoc Committee, which was limited to members of the respondent Medical Staff, it cannot be said that her very presence as well as participation at the proceedings did not influence the actual decision made concerning Dr. Gill's medical staff privileges. There must be a presumption of prejudice when someone in a position of authority with a

demonstrated bias participates in an adjudicatory proceeding.

E. Placing the Burden of Proof on the Physician to Disprove the Allegations that He Is Unqualified, Using a Standard of "Appropriate Showing", Violates Due Process.

At the Ad Hoc Committee hearing, the concept of the burden of proof was stood on its head: the accused party, Petitioner, was forced to prove that the charges made against him were without merit. Article XII, Section 5(h) of the Bylaws (see Appendix "H"), places the burden of proof on the petitioner "for supporting his challenge to the adverse recommendation or decision by an "*appropriate showing*" that the charges and grounds involved lack any factual basis or that such basis or action based thereon is either arbitrary, unreasonable or capricious." (Emphasis added.)

By the mere fact of requesting the hearing, the party against whom serious action is taken (in this case, denial of full medical staff privileges) is converted to the party who must produce clear and convincing proof that the charges against him lack factual basis or are arbitrary, unreasonable or not sustained by the evidence. Under this procedure, respondents may always avoid having to shoulder the burden of proof by taking some action about which a physician will complain and ask for a hearing. Once the physician such as petitioner requests a hearing as he did, respondents no longer need to prove the allegations; they need only argue that petitioner has failed to show a lack of any factual basis for the charges or that the decision taken against him was "arbitrary or unreasonable". In addition to impermissibly shifting the burden of proof to the physician accused of being unqualified to have full medical staff privileges, the standard of proof, "appropriate showing", is unconstitutional and violative of fairness because it is vague and ambiguous. There is no definition of "appropriate showing"

anywhere in the Bylaws nor is this standard of proof anywhere to be found in any area of administrative, civil, or criminal law in the State of California.

The appellate standard of review does not save this bylaw provision. Article VII, Section 6(f) provides as follows:

> "The Board of Directors or its appointed review committee shall act as an appellate body. It shall review the record created in the proceedings, and shall consider the written statement submitted pursuant to subparagraph e of this Section 6, for the purpose of determining whether the adverse recommendation or decision against the affected practitioner was justified and was not arbitrary or capricious."

Article VII, Section 6(f) does not state that the decision of the Ad Hoc Committee need be supported by substantial evidence, or as in *Anton, supra*, "sustained by the evidence". 19 Cal.3d 828, see fn. 27. The bylaws at issue say nothing about what standard of review should be used but instead that require the appellate body to determine whether the decision against the affected physician was "justified and was not arbitrary or capricious". The bylaws provide no guidance to the appellate body determining whether or not the decision of the Ad Hoc Committee could be supported by the evidence before it.

This improper allocation of the burden of proof on petitioner to disprove the charges made against him, especially coupled with the novel standard of "appropriate showing" violates due process. On this issue alone, this matter should be remanded to respondents with instructions either to admit petitioner to full medical staff privileges or to rehear the matter requiring respondent to prove that petitioner is unfit to hold full medical staff privileges by clear and convincing evidence.

IV

CONCLUSION

For these reasons, a Writ of Certiorari should issue to review the judgment and opinion of the California Court of Appeal.

Dated: August 12, 1988

Respectfully Submitted,

LAWRENCE SILVER
A LAW CORPORATION
LAWRENCE SILVER
ELIZABETH KAREN REINHART

By: _____
Lawrence Silver,
Attorneys for Petitioner
Zora S. Gill, M.D.

APPENDIX A

Zora S. GILL, Plaintiff and Appellant,

v.

MERCY HOSPITAL and the Medical Staff of Mercy Hospital, Defendants and Respondents.

No. FOO8277.

Court of Appeal, Fifth District.

March 25, 1988.

OPINION AS MODIFIED ON DENIAL OF REHEARING

March 25, 1988.

GEO. A BROWN, Presiding Justice.*

Appellant, Zora Gill, M.D., appeals from a judgment of the superior court denying a petition for writ of administrative mandamus (Code Civ.Proc., § 1094.5) for review of Mercy Hospital administrative proceedings culminating in the denial to Dr. Gill of full surgical staff privileges by the board of directors of the hospital.[1]

Upon his application, Dr. Gill was granted Mercy Hospital provisional staff privileges at Mercy Hospital in the

*Retired Presiding Justice of the Court of Appeal, sitting under assignment by the Chairperson of the Judicial Council.

[1]During all times pertinent herein the hospital had in place comprehensive written bylaws governing the hearing and appellate procedures to be followed when a doctor receives notice of an executive committee action which "will adversely affect his appointment to or status as a member of the medical staff or his exercise of clinical privileges."

latter part of October 1983 authorizing him to do a broad spectrum of surgery with monitors.[2]

In the latter part of 1984 Dr. Gill requested to be released from all surgical monitoring. The hospital, through its appropriate committees, conducted an investigation into Dr. Gill's surgical practices which culminated on April 24, 1985, in an executive committee determination to advance Dr. Gill to courtesy staff with privileges to perform some simpler procedures without monitoring; these included hernia repair, hemorrhoidectomy, appendectomy, skin biopsy, pilonidal cysts, routine gallbladders, arterioulnoses shunts and arteriovenus fistulas performed in an extremity for access. All other general and vascular surgical procedures required the use of a monitor.

Exercising his right under the hospital bylaws, appellant requested a hearing before an ad hoc hearing committee. An ad hoc hearing committee was appointed, consisting of seven staff doctors who had not participated in any of the adverse recommendations of the executive committee, and an attorney hearing officer. The attorney's participation was limited to advice on procedural issues to assure compliance with the bylaws at the hearing. Dr. Gill appeared personally and by a physician of his choice. The medical staff was also represented by a medical doctor.

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[2]Monitoring of newly appointed surgeons is required by hospital licensure regulations (Cal.Admin.Code, tit. 22, § 70701, subd. (a)(6)), Standards of the Joint Commission on Accreditation of Hospitals (1987) page 122, corporate liability standards (see *Elam v. College Park Hospital* (1982) 132 Cal.App.3d 332, 183 Cal.Rptr. 156) and by the hospital's staff bylaws.

The charges, which were timely served on Dr. Gill, allege he "exhibited a pattern of substandard surgical technique for vascular and complex surgical cases" and that he "exhibits a pattern of poor medical judgment in connection with major surgical cases." These charges were supported by reference to 17 monitor reports which were presented through 6 physician witnesses.

Appellant had the opportunity to present his case and to engage in any questioning of witnesses he wished.

Following the hearing, the committee voted six-to-one in favor of the executive committee's recommendation limiting Dr. Gill's hospital privileges. In support of the decision, the committee found:

> "1. Dr. Gill's performance in several cases demonstrated either significant errors in judgement [*sic*] or a significant problem in technique related to major general or vascular surgery;
>
> "2. Dr. Gill demonstrated particularly poor surgical judgement [*sic*] in connection with Case #136165, in which surgery was excessively delayed in the case of a spleen injury;
>
> "3. Dr. Gill's monitor reports at Mercy Hospital constitute a sufficient pattern and number of reports to demonstrate that he failed to make expected improvement in surgical technique in major general and vascular cases during his tenure as a member of the provisional staff;
>
> "4. Dr. Gill failed to adequately refute the charges contained in the Notice of Charges substantiated by monitor reports; and,
>
> "5. Neither Dr. Gill, nor his witnesses, presented objective evidence showing excellent surgical tech-

> nique and judgement [*sic*] in patient care to counter the recommendation of the Executive Committee."

Puresuant to the bylaws, Dr. Gill appealed to the board of directors of the hospital. At the hearing before the board, appellant was represented by an attorney and presented additional clinical evidence in the form of a letter and report by Robert Pereyra, M.D., addressing cases which had been presented to the ad hoc hearing committee; through counsel he also presented a legal brief. In response, Dr. Deaner, representing the medical staff, presented rebuttal to Dr. Pereyra's letter.

Sister Phyllis Hughes, president of the hospital and member of the board of directors, disqualified herself from participation in the appellate process. Hughes took this action because she had written a letter regarding one of the monitored cases and was present during the deliberations of the ad hoc committee.

The board of directors upheld the ad hoc committee's decision.

This petition to the superior court followed.

DISCUSSION

Appellant raises numerous arguments in support of his prayer for reversal. We shall consider those points seriatim. However, before doing so, we observe that many of his points urge a violation of constitutional due process. It is settled that when "a private association is legally required to refrain from arbitrary action, the association action must be both substantively rational and procedurally fair." (*Pinsker v. Pacific Coast Society of Orthodontists* (1974) 12 Cal.3d 541, 550, 116 Cal.Rptr. 245, 526 P.2d 253.) The essence of the concept is that the action cannot be arbitrary or capricious. It is more appropriate to refer

to this standard in terms of "fair procedure" in a nonconstitutional sense rather than due process in the constitutional sense. (*Id.* at p. 550, fn. 7, 116 Cal.Rptr. 245, 526 P.2d 253.) The essence of the right is one of fairness. (*Applebaum v. Board of Directors* (1980) 104 Cal.App.3d 648, 657, 163 Cal.Rptr. 831.)

I

Substantial Evidence

[1] Appellant argues that substantial evidence does not support the decision. Code of Civil Procedure section 1094.5, subdivision (d)[3] establishes the substantial evidence test as the applicable standard of review. When an appellate court is reviewing a quasi-judicial decision of a governing body of a private hospital, the function of the appellate court is the same as that of the trial court in conducting the review. Therefore, this court should review the entire record to determine whether the decision is supported by substantial evidence. (*See Pick v. Santa Ana-Tustin Community Hospital* (1982) 130 Cal.App.3d 970, 979-980, 182 Cal.Rptr. 85; see also *Schmitt v. City of Rialto* (1985) 164 Cal.App.3d 494, 501, 210 Cal.Rptr. 788.) In this regard, we are cognizant of the strong public policy in favor of effective medical peer review by hospitals. In *Unterthiner v. Desert Hospital Dist.* (1983) 33 Cal.3d 285, 188 Cal.Rptr. 590, 656 P.2d 554, the Supreme

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[3]Code of Civil Procedure section 1094.5, subdivision (d), provides in relevant part:

> "(d) Notwithstanding the provisions of subdivision (c), in cases arising from private hospital boards . . . , abuse of discretion is established if the court determines that the findings are not supported by substantial evidence in the light of the whole record. . . ."

Court recognized that a "doctor's license . . . does not determine qualification for hospital privileges or establish competence to engage in specialties in the hospital. . . ." Indeed, the "determination of the standards to be applied in granting privileges involves a legislative judgment and just as courts have largely deferred to administrative expertise in determining whether an applicant is qualified to practice a profession . . . they should defer to administrative expertise in determining whether the professional is qualified to take on additional responsibilities involved in a grant of hospital privileges." (*Id.* at p. 298, 188 Cal.Rptr. 590, 656 P.2d 554; see also *Cipriotti v. Board of Directors* (1983) 147 Cal.App.3d 144, 157, 196 Cal.Rptr. 367.)

[2] Substantial evidence clearly supports the decisions of the hospital board, the ad hoc committee and the trial court in this case. The charges filed against appellant alleged he (1) "exhibited a pattern of substandard surgical technique for vascular and complex major surgical cases," and (2) "exhibited a pattern of poor medical judgment in connection with major surgical cases." At the ad hoc committee hearing the various physicians who prepared the monitor reports presented those reports to the committee. Patient charts and a letter from a hospital radiologist were also introduced to support the charges.

The first monitor report was presented by Dr. Deaner who observed appellant while he performed a femoral bypass. In the report, Dr. Deaner criticized appellant for using a graft that was too long. Dr. Deaner noted that because appellant had to remove a section of the graft, the procedure was lengthened 20-30 minutes.

The next case presented by Dr. Deaner involved the insertion of a graft in the left forearm of a patient. Dr. Deaner's criticism focused on the fact the graft soon

failed, requiring two further surgeries to declot the graft. Although appellant was of the opinion these grafts had a 20 percent failure rate, the other physicians at the hearing felt the failure rate was actually only 5 percent.

In the third case Dr. Deaner was critical of appellant's decision to tie a knot inside an artery. Although Dr. Deaner reported appellant recognized his own error and removed the stitch, Dr. Deaner felt this was an error that should not have been made.

In the next report Dr. Deaner was critical of appellant's rough handling of tissue. In the final case presented by Dr. Deaner, he observed a tremor in appellant's hands as he began to operate. Dr. Deaner also notes that additional sutures had to be placed in the artery.

Dr. Loos was the next physician to present a series of monitor reports. In his first report, Dr. Loos was critical of appellant's choice of procedure given the patient's prior medical history. Based on the history Dr. Loos felt appellant should have concluded his chosen procedure would prove unsuccessful in the long run.

In the next report Dr. Loos had only a minor criticism involving excessive bleeding. The third case monitored by Dr. Loos involved the removal of gallbladder stones from a patient with a history of injury to common duct tissue. Dr. Loos was of the opinion appellant should have selected a more experienced assistant for such a complex surgery. Dr. Loos also criticized appellant's suturing technique, which he instructed appellant to re-do during surgery. Dr. Loos believed that if the suturing was not corrected leakage would occur.

In his next report Dr. Loos was critical of appellant's decision to remove an appendix while performing surgery

to correct another problem. It was Dr. Loos's opinion the surgery should be left as straightforward as possible to avoid potential problems with infection.

The next case reported by Dr. Loos which is relevant to the first charge involved a surgery scheduled by appellant to repair a hernia. Dr. Loos felt the patient was too ill for the surgery. After Dr. Loos discussed his concerns with appellant, the surgery was cancelled.

Dr. O'Reilly, in his presentation, felt appellant's surgical technique was rough and his use of the assistant not effective. In addition, Dr. O'Reilly felt appellant's surgical techniques did not meet the average standard of care.

Dr. Charles Owens reported on a case where, again, appellant performed an appendectomy while performing another surgical procedure. Dr. Owens believed the appendectomy should not have been performed given the age of the patient.

The next case presented did not involve a monitor report of a surgery, but consisted of a letter by Dr. Maclennan, prepared after his contact with a case. In this case involving a juvenile, Dr. Maclennan was asked to perform a CT scan to rule out a spleen injury. Dr. Maclennan became very concerned over the patient's condition and immediately phoned appellant. Dr. Maclennan was concerned because, although the patient seemed acutely ill, the CT scan was ordered as a non-emergency procedure. When he was not immediately able to reach appellant, Dr. Maclennan peformed the scan and noticed a blood density surrounding the spleen. Upon finally talking to appellant, Dr. Maclennan impressed upon him the severity of the injury. Dr. Maclennan was of the opinion appellant did not fully understand the urgency of the situation at first.

At this point in the hearing, appellant explained that he moved slowly on this case because of the patient's mother, who did not want to leave her child in the hospital. After talking to her for quite some time, appellant was able to get her to agree to admit the child and schedule a CT scan. Because the patient was stable, appellant felt it was appropriate to wait awhile for the family to come to an agreement on surgery. Appellant also noted that at the time Dr. Maclennan called him, he had already received a report showing the patient's hemoglobin count to be low and was in the process of trying to explain to the family surgery was needed immediately. Once the family agreed, appellant stated there was a delay in getting into surgery because an operating room was not available.[4]

Related to this case, a memorandum from Sister Phyllis Hughes was put into the record. In the memorandum, Sister Hughes reported a conversation she had with the mother of the patient in the juvenile spleen case last referred to. The mother told Sister Hughes she had been contacted by appellant and asked to write a letter stating her son's surgery was delayed at her request. The mother did not want to write the letter because, she told Sister Hughes, appellant advised her to wait on surgery to see if the bleeding would stop on its own. Sister Hughes thereafter told the mother she felt the letter was unnecessary.[5]

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[4]The superior court in its tentative decision disregarded the evidence surrounding the juvenile spleen case. The court felt appellant was unfairly deprived of access to the monitor report of the surgery in this case. However, the court was still able to conclude there was adequate evidence to support the findings of the ad hoc committee.

[5]In its tentative decision, the superior court found Sister Hughes had unfairly prevented appellant from obtaining evidence by her actions. However, because the facts of this particular case were not

The final monitor report was presented by Dr. Palitz and involved a hemorrhoidectomy. Dr. Palitz criticized the post-operative care of the patient, which he did not feel was adequately supervised by appellant.

At this point appellant was given the opportunity to respond to the evidence presented on behalf of the executive committee. Appellant addressed some of the criticism and explained his actions in each case. A physician who assisted appellant on at least one surgery expressed his opinion that appellant's surgical skills were good. Finally, appellant was very critical of the monitoring system which he claimed forced him to transfer cases when monitors were not available and to delay surgeries.

At the hearing before the hospital's board of directors, appellant was permitted to present additional clinical evidence in the form of a letter from Robert Pereyra, M.D., of Los Angeles, which contained a detailed response to the monitored cases which had been presented to the ad hoc hearing committee. Dr. Deaner, on behalf of the medical staff, presented rebuttal comments to the observations and conclusions of Dr. Pereyra. The recited evidence clearly supplies substantial evidence to support the conclusions appellant exhibited a pattern of substandard surgical techniques and poor medical judgment in connection with major surgical cases. Appellant's selective recitation of favorable evidence appearing in the record does not compel a contrary result. It is not appropriate that this court resolve conflicts in the evidence favorable to the appellant; it is our legal obligation to resolve conflicts in support of the judgment.

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considered by the court in its decision, the court concluded appellant was not prejudiced.

II

Representation by Legal Counsel

The bylaws provide:

> "e. The affected practitioner shall be entitled to be accompanied by and represented at the hearing by a member of the medical staff in good standing or by a member of his local professional society."
>
> " . . .
>
> "j. The hearings provided for in these bylaws are for the purpose of resolving, on an intra-professional basis, matters bearing on professional competence and conduct. Accordingly, neither the affected practitioner, nor the Executive Committee of the medical staff or the Board of Directors, shall be represented at any phase of the hearing procedure by an attorney at law unless the Board of Directors, in its discretion, permits both sides to be represented by counsel. The foregoing shall not be deemed to deprive the practitioner, the Executive Committee of the medical staff, or the Board of Directors of the right to legal counsel in connection with preparation for the hearing or for a possible appeal. If a hearing officer is utilized, he may be an attorney at law."

[3] Appellant was represented by a doctor but was denied the right to be represented by a lawyer at the ad hoc committee meeting. He was so notified in the charging document. He was, however, represented by an attorney at the hearing before the board of directors. He contends this denied him a fair hearing before the ad hoc committee.

In *Anton v. San Antonio Community Hosp.* (1977) 19 Cal.3d 802, 827, 140 Cal.Rptr. 442, 567 P.2d 1162, the

hospital's bylaws provided in substance that because the hearing was for the purpose of intraprofessional resolution of matters bearing on conduct or professional competency, attorney representation would not be permitted. The Supreme Court held that due process or the requirement of a fair hearing is not violated when the hospital does not permit the doctor to be represented by counsel at a factual peer review hearing.

In *Cipriotti v. Board of Directors, supra,* 147 Cal.App.3d 144, 196 Cal.Rptr. 367, the court upheld the right of California hospitals to pursue peer review by a medical staff hearing without attorney representation and concluded due process was not violated. (*Id.* at p. 157, 196 Cal.Rptr. 367.)

[4] Appellant argues the results in these cases should be changed because of the provisions of Business and Professions Code section 805 and the effect of a recent federal antitrust case entitled *Patrick v. Burget* (9th Cir.1986) 800 F.2d 1498, cert. granted, (1987) ____ U.S. ____, 108 S.Ct. 65, 98 L.Ed.2d 29. He argues that these two authorities require the presence of retained counsel at the hearing before a peer review committee. We disagree.

Business and Professions Code section 805 requires hospitals to report to the State Board of Medical Quality Assurance, the state physician licensing agency, when hospital action is taken regarding a physician's staff privileges. This requirement was in effect since 1979, long before the decision in *Cipriotti v. Board of Directors, supra,* 147 Cal.App.3d 144, 196 Cal.Rptr. 367, holding that the presence of an attorney at a hospital staff peer review proceeding is not required. We fail to perceive how the reporting requirement has such a drastic effect upon

the proceedings as to require representation by an attorney.

As has been pointed out, the purpose of the peer review process is to resolve intraprofessionally matters bearing upon a physician's competency and conduct. To this end, the affected physician is entitled to be represented by another physician on the medical staff or from the local professional society. Furthermore, the bylaws specify numerous provisions which are meant to guarantee the affected physician a fair proceeding. These include prompt notice of the charges, together with the documentary support for the charges; adequate time to prepare to meet the charges; a hearing before a committee of doctors who have no prior involvement in the charges; representation by a fellow doctor; the right to appeal to the board of directors of the hospital and representation by counsel at the appellate hearing.

The purpose of the proceeding is to review highly technical documents and medical reports dealing with the doctors' performance in an area where experts in the same field can arrive at a decision without the controversial and contentious atmosphere which would likely be created by the participation of attorneys. Medical staff hearings involve highly educated individuals. There is little risk that a physician will be erroneously deprived of staff privileges if he is not allowed counsel at the hearing. The physician's position is decidedly dissimilar to that of a criminal defendant or an incarcerated defendant faced with a civil suit involving the potential for substantial civil damages (*Payne v. Superior Court* (1976) 17 Cal.3d 908, 132 Cal.Rptr. 405, 553, P.2d 565) or a welfare recipient whose benefits are being terminated (*McCullough v. Terzian* (1970) 2 Cal.3d 647, 87 Cal.Rptr. 195, 470 P.2d 4) or a minor committed to a state psychiatric

facility (*In re Roger S.* (1977) 19 Cal.3d 921, 938, 141 Cal.Rptr. 298, 569 P.2d 1286).

[5] Appellant's argument with regard to *Patrick v. Burget, supra,* 800 F.2d 1498, is wanting. In that case, which arose in the State of Oregon, the court determined that state mandated medical staff peer review actions are exempt from federal antitrust statutes under the "state action" antitrust doctrine where the state requires private parties to conduct peer review and supervise the process through administrative and judicial review. From that premise, appellant argues that the California law is similar to the Oregon law, a state action in the antitrust statute is the same as state action in the constitutional due process sense, that federal constitutional due process therefore applies to peer review proceedings and, finally, that federal due process requires the presence of an attorney at peer review hearings. This concatenated argument is flawed by the weakness of the links connecting the premise with the ultimate conclusion. "State action" as used in the antitrust statutes to exempt the state from the Sherman Antitrust Act has no essential relationship to "state action" as a prerequisite to the invocation of federal due process under the United States Constitution. Indeed, federal cases on the subject have held that actions of a private hospital in medical staff proceedings, like the instant case, are not sufficiently involved with the state or federal governmental authority to qualify as "state action" that is subject to the procedural due process requirements of the United States Constitution. (*Goss v. Memorial Hosp. System* (5th Cir.1986) 789 F.2d 353; *Lubin v. Crittenden Hosp. Assn.* (8th Cir. 1983) 713 F.2d 414.)

Secondly, assuming there is state action so as to require compliance by the state with federal due process,

appellants cite no case in a hospital peer review context holding that federal due process requires that a doctor subject to such a review be afforded an opportunity to be represented by an attorney. Indeed, for the reasons we have discussed, fundamental fairness does not require legal representation. Essentially there is no real difference between fair procedure and due process rights. The distinction is one of origin rather than one of the extent of the protection afforded to the individual. "[T]he essence of both rights is fairness." (*Applebaum v. Board of Directors, supra,* 104 Cal.App.3d 648, 657, 163 Cal.Rptr. 831.)

[6] In his reply brief, appellant asserts that the Health Care Quality Improvement Act of 1986 (HCQIA) (42 U.S.C. §§ 11111-11152) requires that Dr. Gill be given the right to an attorney at his peer review committee hearing. In sum, the act establishes a national clearing house of medical peer review and malpractice information and provides qualified immunity from certain federal and state laws for peer review actions taken in good faith. The act was passed in October 1986 and has an effective date of October 17, 1987. Apparently the reporting requirements are still awaiting the promulgation reporting regulations to be issued by the Secretary of Health and Human Services.

Since the hearing and hospital's final decision in this matter occurred long before the effective date of the act, it obviously could not be applied to these proceedings. In any event, a review of the act satisfies us that it was not the intent of Congress to modify existing California peer review hearing procedures.

III

Nonparticipation of Appellant in the Decision that Attorney Representation Would Not Be Allowed

[7] Appellant argues that the denial of counsel without giving him an opportunity to participate in the decision denied him a fair hearing. In the formal notice of charges and hearing, appellant was advised that he would not be represented by legal counsel.

The bylaw provision quoted *ante* at pages 310-311 permits the Board in its discretion to allow both sides to be represented by counsel.

Thus, as in *Anton v. San Antonio Community Hosp., supra,* 19 Cal.3d at page 827, 140 Cal.Rptr. 442, 567 P.2d 1162, the board of directors could have in its discretion permitted representation by counsel. However, no authority is cited which requires participation by either the ad hoc committee or the doctor in that decision.

In *Cipriotti v. Board of Directors, supra,* 147 Cal.App.3d at page 156, 196 Cal. Rptr. 367, the bylaws specifically provided that a lawyer may not represent a party. The court upheld the procedure, stating in part:

> "So long as a fair hearing is provided, in disciplining or suspending those who do not meet its professional standards, the hospital should not be hampered by formalities not required by its bylaws nor by due process considerations. Fair hearing includes ample notice, opportunity to hear and corss-examine witnesses and to present evidence." (*Cipriotti v. Board of Directors, supra,* 147 Cal.App.3d at p. 157, 196 Cal.Rptr. 367.)

Since appellant can be totally denied counsel, failure to permit him to participate in a decision leading to that

result adds nothing to his argument that he was denied a fair hearing.

IV

Adequate Substitute For Legal Counsel

[8] Under the bylaws, appellant is entitled to be "accompanied by and represented at the hearing by a member of the medical staff in good standing or by a member of his local professional society."

Appellant states he intended to call upon a Los Angeles area physician who was prepared to represent him before the ad hoc committee. When he learned he would be unable to rely upon this physician because of the bylaw provision, appellant was forced to rely on a representative from Kern County. Appellant notes this representative did little or nothing for him during the hearing. It is on this basis appellant argues the bylaw provision prejudiced him.

Appellant cites to no legal authority to support his contention the bylaw provision caused him to be inadequately represented at the hearing per se. (Cal.Rules of Court, rule 15; *Burger v. Godden* (1985) 163 Cal.App.3d 1113, 1119, 210 Cal.Rptr. 109.) Nor does appellant cite any practical reason why a physician from Los Angeles would have offered him better representation than one from the local area. Appellant's challenge here seems to be more focused on his displeasure with the particular representative he chose rather than on the adequacy of representation in general. Appellant was not denied a fair hearing simply because in retrospect his representative was not as aggressive as he would have preferred.

V

Burden of Proof

[9] Appellant contends that the bylaws unfairly and improperly place the burden of proof on him to disprove the charges. He is in error. When read as a whole, the bylaws do not place the burden of proof on appellant; further, more adverse provisions have been approved by the courts.

The bylaws provide in substance that when a practitioner receives notice of a recommendation of the executive committee that will adversely affect his or her status on the medical staff, he or she is entitled to a noticed hearing in front of an ad hoc committee of the medical staff and to appellate review before the board of directors. Notice of the hearing must be sent informing the practitioner of the "acts or omissions with which the practitioner is charged, a list of specific or representative charts being questioned, and/or the other reasons or subject matter that was considered in making the adverse recommendation or decision." A member of the executive committee or other representative shall represent the executive committee "at the hearing to present the facts in support of its adverse recommendation and to examine witnesses." The bylaw continues, "It shall be the obligation of such representative to present appropriate evidence in support of the adverse recommendation or decision, but the affected practitioner shall thereafter be responsible for supporting his challenge to the adverse recommendation or decision by an appropriate showing that the charges or grounds involved lack any factual basis or that such basis or any action based thereon is either arbitrary, unreasonable or capricious."

It is evident from the above bylaw provisions that the executive committee is responsible for not only specifying the allegations but also for first presenting evidence which factually supports those allegations. It is only after the factual basis is presented that the affected physician gets the opportunity to refute the allegations and the evidence. This procedure was followed in this case.

In *Anton v. San Antonio Community Hospital, supra,* 19 Cal.3d 802, 828-829, 140 Cal.Rptr. 442, 567 P.2d 1162, the Supreme Court upheld a bylaw against a similar contention which was clearly more unfavorable to the doctor than the bylaws in the instant case.[6] The court observed that the bylaws, read as a whole, "contemplates a substantial showing on the part of the charging committee in support of its recommendation." (*Id.* at pp. 829-830, 140 Cal.Rptr. 442, 567 P.2d 1162.) In light of the language of the bylaws herein more favorable to appellant than those in *Anton*, it is specious to argue that the bylaw in the instant case unfairly places the burden of proof on the appellant.

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[6]The bylaw at issue in *Anton* provided:

> " 'At any hearing involving any of the grounds for hearing specified [which include denial of reappointment and suspension of membership] . . . it shall be incumbent on the person who requested the hearing to initially come forward with evidence in support of his position. . . . [¶] In all cases in which a hearing is conducted under this Article, after all evidence has been submitted by both sides, the Judicial Review Committee shall rule against the person who requested the hearing unless it finds that said person has proved, by clear and convincing proof, that the action of the committee or body whose decision prompted the hearing was arbitrary, unreasonable, or not sustained by the evidence.' " (*Anton v. San Antonio Community Hosp., supra,* 19 Cal.3d at p. 828, 140 Cal.Rptr. 442, 567 P.2d 1162, fn. omitted.)

Contrary to appellant's contention, the facts of this case are not similar to those of *Pipkin v. Board of Supervisors* (1978) 82 Cal.App.3d 652, 147 Cal.Rptr. 502, which accepted the language of *Anton* but found the bylaws unfairly placed the burden on the person being charged. In *Pipkin*, a deputy sheriff in the Shasta County jail was dismissed from her job. The Shasta County ordinance provided only for a post-termination hearing to contest the action. (*Id.* at p. 656, 147 Cal.Rptr. 502.) The *Pipkin* court discussed the analysis in *Anton* and concluded, after conducting a review of the applicable Shasta County procedures, that unlike the bylaw in *Anton*, the procedures were unfair. (*Id.* at p. 658, 147 Cal.Rptr. 502.) The *Pipkin* court explained that the only affirmative duty the county counsel had to perform was to " 'prepare an order, in writing, stating specifically the cause for such an action.' " The remaining burdens of requesting a hearing and proving the charges untrue were placed on the person charged. (*Ibid.*) Unlike *Anton*, where a reading of the entire bylaws caused the court to conclude the decision had to be supported by evidence that was at least substantial, the *Pipkin* court felt the procedures in its case violated the "axiom that, "in disciplinary administrative proceedings, the burden of proving the charges rests upon the party making the charges.' " (*Ibid.*)

[10] Regarding appellate review in this case, the bylaws state:

> "f. The Board of Directors . . . shall act as an appellate body. It shall review the record created in the proceedings, and shall consider the written statements submitted pursuant to subparagraph e of this Section 6, for the purpose of determining whether the adverse recommendation or decision against the af-

fected practitioner was justified and was not arbitrary or capricious."

Appellant contends he was denied a fair review because the bylaw fails to state a standard of review. Any deficiency in this regard was filled in by the board's hearing officer who instructed the board to use the substantial evidence test. Specifically, he instructed the Board "that you are obligated to make review of the record and determine whether there is substantial evidence that would support the decision made by the medical staff." As the trial judge concluded:

> "(f) The finding of the Hospital Board of Directors, whatever the standard of proof set forth in the bylaws, was properly based upon a substantial evidence test."

VI

Denial of Discovery

Appellant contends he was denied discovery in three areas: (1) The monitor's report of Dr. Lee Richards in case No. 136165, the juvenile spleen case (hereinafter referred to as the spleen case); (2) Access to all of appellant's monitor reports, as requested by letter dated March 26, and not just the ones forming the basis of the instant charges; and (3) The records on other physicians admitted to the staff of the hospital.

No formal right to discovery exists in an administrative hearing not subject to the Administrative Procedures Act. (*Smith v. Vallejo General Hospital* (1985) 170 Cal.App.3d 450, 459, 216 Cal.Rptr. 189; see also Cal. Administrative Hearing Practice (Cont.Ed.Bar 1984) Non-APA Discovery, § 2.72, p. 107.) However, it is safe to say that "fair procedure" requires disclosure of all evidence forming the

basis of the charges and any other evidence which is made available to the hearing panel. (*Hackethal v. California Medical Assn.* (1982) 138 Cal.App.3d 435, 444, 187 Cal.Rptr. 811.)

[11] As to (3), there is no citation to the record supporting the request or to any response that the hospital may have made to the request, if any. We therefore will not consider this point. (*Smith v. Vallejo General Hospital, supra,* 170 Cal.App.3d 450, 459, 216 Cal.Rptr. 189.)

[12] As to (1), the trial court found:

> "(a) Petitioner should have been allowed discovery of, and introduction of the monitor report of Dr. Lee Richards, who attended the surgery in that matter [referring to the spleen matter]."

and that,

> "(h) With the exception of the discovery issue dealt with regarding the aforementioned spleen case, petitioner was afforded ample discovery to effectively represent his interests at the hearing conducted by respondent."

The court then stated that the decision of the board was supported by substantial evidence, even though it disregarded the evidence regarding the spleen case.

We agree with the trial court that the heretofore recited evidence was sufficient to support the hospital's order. Though appellant may have been denied access to that monitor report, he suffered no prejudice as a result of the omission. The spleen case was presented as evidence to support the charge appellant showed poor medical judgment. The focus of the presentation concerned appellant's actions prior to surgery and whether too much time was taken in making the decision to proceed with surgery. Therefore, a monitor's report covering appellant's per-

formance during surgery would not address the primary concerns involved in this case. We have no real doubt that the result reached by the ad hoc committee and the executive board would have been the same even though the evidence regarding the spleen case had not been before them. (*Miller v. Eisenhower Medical Center* (1980) 27 Cal.3d 614, 635, 166 Cal.Rptr. 826, 614 P.2d 258.)

[13] As to (2), *ante,* the record is entirely unclear as to whether any of this information was supplied. Assuming it was not, we agree with the trial court that discovery of all of appellant's monitor reports, even though not a basis for any of the charges in this case, was not required by the fair hearing doctrine. The purpose of the ad hoc committee hearing was to resolve "on an intra-professional basis, matters bearing on professional competency and conduct." Appellants' competency and conduct were challenged in numerous cases. The hearing was meant to explore these charges and determine whether the charges as to those specific cases met the professional standards expected of physicians with full privileges. The exploration of cases not involved in the specific charges would have had only a tangential relation to the specific charges and would have extended the hearings into collateral matters. The committee had the discretion to deny discovery of these reports.

VII

Prevention of Cross-Examination

[14] Appellant contends that none of the witnesses who testified on behalf of the medical staff was cross-examined and that he was denied the opportunity to do so. These assertions inaccurately represent the record and are without merit.

Initially it is noted that the bylaws provide for the right to cross-examine.

> "i. The affected practitioner shall have the following rights: to call and examine witnesses, to introduce written evidence, to cross-examine any witnesses or any matter relevant to the issue of the hearing, to challenge any witnesses and to rebut any evidence. . . ."

There is no indication in the record of the hearing that appellant was ever told he could not cross-examine the witnesses presented on behalf of the medical staff. In fact, appellant actually did ask questions of a number of witnesses who appeared on behalf of the medical staff. Furthermore, at numerous points during the hearing the chairman asked everyone if they had any further questions of the witnesses. The record does not support the conclusion this meant everyone but appellant.

Appellant seems to be basing his contentions on the fact that throughout the presentation of the monitors' reports he continually asked for the opportunity to present rebuttal evidence. Appellant was repeatedly told he would get this opportunity after all the reports were presented. This did not involve the right to cross-examination, but instead dealt with the order of proof.

VIII

Introduction of Hearsay Evidence

[15] The hearsay evidence being challenged consists of a memorandum prepared by Sister Phyllis Hughes on the same day she was visited by the mother of the juvenile in the spleen case. The memorandum, as read at the hearing, provided as follows:

> "Mrs. Bradley visited me today, date is October 24, 1985, to ask what was going on, because Dr. Gill keeps asking her to write a letter to the hospital, with a copy to him, stating that her son's surgery was delayed at her request. Mrs. Bradley told me that she was advised by the doctor to wait on the surgery to quote see if the bleeding would stop close quote. Therefore, she does not want to write a letter. She also is feeling very pressured by Dr. Gill's repeated insistence. I told Mrs. Bradley that I felt such a letter is unnecessary. I explained that the medical staff has a routine peer review process, during which they ask questions of one another about aspects of cases. This was probably the reason for the doctor's request."

This memorandum was introduced into evidence.

Although uncorroborated hearsay evidence cannot, by itself, support an administrative finding, hearsay evidence together with other reliable evidence may support a finding (*Cipriotti v. Board of Directors, supra,* 147 Cal.App.3d 144, 155, fn. 2, 196 Cal.Rptr. 367.) In fact, the hospital bylaws make no reference to the admissibility of hearsay and state instead:

> "The hearing need not be conducted strictly according to the rules of law relating to the examination of witnesses or presentation of evidence. Any relevant matter upon which responsible persons customarily rely in the conduct of serious affairs shall be considered, regardless of the existence of any common law or statutory rule which might make evidence inadmissible over objection in civil or criminal action. The practitioner for whom the hearing is being held shall, prior to or during the hearing, be entitled to submit memoranda concerning any issue of procedure or of

> fact and such memoranda shall become a part of the hearing record."

Although the memorandum is clearly hearsay evidence, it is not unreliable evidence. It appears the memorandum was prepared shortly after sister Hughes' conversation with the mother while the information was fresh. This makes the memorandum a more accurate statement of what occurred during that conversation than an unrefreshed oral recollection some months after the actual conversation.

Furthermore, there was other substantial evidence on the issue of appellant's medical judgment. The other evidence presented at the hearing adequately supports the finding appellant's medical judgment did not meet the standards required for unmonitored status on the medical staff.

Interestingly, appellant introduced at the hearing on appeal before the board a hearsay letter from Robert Pereyra, M.D., addressing in detail the varius monitor reports which had been presented to the ad hoc committee.

IX

Bias of Dr. Ramon Neufeld, Chairman of the Ad Hoc Committee.

Contending Dr. Neufeld continually took the role of adversary instead of imparital fact finder, appellant alleges Dr. Neufeld was biased and that this bias deprived him of a fair hearing. To support this claim appellant cites numerous episodes that occurred during the ad hoc committee hearing. Specifically, appellant asserts Dr. Neufeld prevented him from cross-examining the witness (dealt with in issue VII), interrupted him repeatedly, and

caused him to rush through his rebuttal evidence. While appellant makes some conclusional arguments in this regard grounded on excerpts from remarks taken out of context, the record as a whole does not support the charge of bias. On the contrary, it supports the view that Dr. Neufeld acted as a neutral facilitator of the proceedings.

In *Andrews v. Agricultural Labor Relations Bd.* (1981) 28 Cal.3d 781, 171 Cal.Rptr. 590, 623 P.2d 151, the Supreme Court set forth the standard for determining whether bias of a hearing officer constitutes a sufficient basis for disqualification.

> " 'In order for the judge to be disqualified the prejudice must be against a particular party [citations] *and* sufficient to impair the judge's impartiality so that it appears probable that a fair trial connot be held.' (Italics added.)" (*Id.* at p. 792, 171 Cal.Rptr. 590, 623 P.2d 151.)

In reviewing the evidence, it must be remembered the evidence of bias must be "concrete" rather than frivolous or conclusional. (*Ibid.*) " 'Bias and prejudice are never implied and must be established by clear averments.' " (*Ibid.*) Furthermore, the mere appearance of bias is not sufficient. (*Id.* at p. 793, 171 Cal.Rptr. 590, 623 P.2d 151.)

The record does not establish that Dr. Neufeld was biased in his approach to the case or in his attitude toward or treatment of appellant.

X

Presence of Sister Phyllis Hughes, President of the Hospital, at the Ad Hoc Hearing

[16] Appellant next challenges the presence of Sister Hughes during the ad hoc committee's proceedings. Ap-

pellant argues it was error to "have anyone who is biased or prejudiced on the body . . . especially someone who has considerable power . . . sit and watch the deliberations."

Appellant's assertions regarding Sister Hughes lack any foundation. The record offers absolutely no support for the conclusion Sister Hughes had any bias against appellant. Furthermore, there is no basis for concluding Sister Hughes had any influence over the final decision of the ad hoc committee. During some recorded discussions following the board of directors' meeting, appellant's attorney asked the attorney for the Mercy Hospital Medical Executive Committee whether Sister Hughes sat in on the ad hoc committee's deliberations. Following a break, the attorney for the hospital responded as follows:

> "MR. JOHNSON: I am advised by Sister Phyllis that she was requested by the ad hoc committee hearing to be present during the deliberations and was, in fact, present during the deliberations. I asked her if questions were asked of her and she indicated there were some questions asked of her, primarily in two categories: one, there was a question asked of her concerning a procedure at another hospital and she indicated that she did not think it was appropriate to go into that and declined to give any answer. The other questions that were asked of her she characterized as all being procedural type questions relating to the Bylaws and the process of what were the mechanics to be. She indicates that at no time was she asked any question or did she volunteer any information concerning the merits of the issues presented to that committee."

Appellant has failed to provide any evidence indicating Sister Hughes offered more than information on procedure during deliberations or that she was biased against

appellant or unduly influenced the ad hoc committee's deliberations.

XI

Denial of Equal Protection by Application of Code of Civil Procedure Section 1094.5 Standard of Review

[17] Appellant asserts he was denied equal protection of the law by application of the substantial evidence test set forth in Code of Civil Procedure section 1094.5, subdivision (d), which states in pertinent part:

> "(d) Notwithstanding subdivision (c), in cases arising from private hospital boards or boards of directors of districts organized pursuant to The Local Hospital District Law, Division 23 (commencing with Section 32000) of the Health and Safety Code, abuse of discretion is established if the court determines that the findings are not supported by substantial evidence in the light of the whole record."

Following the express provisions of the section, the trial court, in denying mandate, applied the substantial evidence test.

Appellant argues that since there are public hospitals in large urban areas which are not "organized pursuant to the local hospital district law, division 23 (commencing with section 32000) of the Health and Safety Code," he has been denied equal protection because a doctor seeking membership on the staff of such a hospital is entitled to have a trial court examine the record and exercise its independent judgment in reviewing the administrative decision of the hospital. (See Code Civ.Proc. § 1094.5, subd. (c).)

This issue has been thoroughly discussed and decided adverse to appellant's contentions in *Anton II (Anton v. San Antonio Community Hospital* (1982) 132 Cal.App.3d 638, 650-657, 183 Cal.Rptr. 423, per Kaufman, J. [now a member of the Supreme Court of California]). We see no point in engaging in further discussion of the issue and choose to follow *Anton II.*[7]

The judgment is affirmed.

WOOLPERT, Acting P.J., and HAMLIN, J., concur.

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[7]It is true that as of the time of the *Anton II* decision the statute provided in relevant part: ". . . in cases arising from private hospital boards, abuse of discretion is established if the court determines that the findings are not supported by substantial evidence in the light of the whole record." (*Anton II,* at p. 645, 183 Cal.Rptr. 423.) Thus, the court's due process and equal protection discussion dealt with all private hospitals, vis-a-vis all public hospitals. The fact the statute was amended in 1982 to lump local district hospitals in the same category as private hospitals but left at large a class of public hospitals subject to the independent judgment test does not, in our opinion, impair the validity of the court's reasoning in rejecting the constitutional attack on the statute.

APPENDIX B

[Letterhead of the California Medical Association]

April 27, 1988

The Honorable Malcolm Lucas, Chief Justice
The Honorable Associate Justices of the
Supreme Court of California
4250 State Building, 350 McAllister Street
San Francisco, CA 94102

Re: *Gill v. Mercy Hospital*
No.: _____
5th Civ. No. F008277

Dear Chief Justice Lucas and Associate Justices:

On behalf of the California Medical Association, we respectfully request that this Court decertify the opinion in the above-entitled case or grant the review requested by Petitioner Zora S. Gill, M.D.[1]

The California Medical Association is a non-profit unincorporated professional association of approximately 33,000 physicians practicing in the State of California. CMA's membership includes most of the California physicians who are engaged in the private practice of medicine, in all specialties. The Association's primary purposes are: " . . . to promote the science and art of medicine, the care and well-being of patients, the protection of the public health, and the betterment of the medical profession . . . ".

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[1]We also understand that similar issues are raised in another case pending before this Court, *Sywak v. O'Connor Hospital* No. _____ (6th Civ. No. H001982.

A. INTRODUCTION

A procedure which permits the prosecutor to select the evidence which it will divulge, determine whether legal representation will be permitted, shift the burden of proof, permit a witness for the prosecution to participate in the jury's deliberations, and limit judicial review to a search for substantial evidence supporting the verdict, is neither "fair" nor reasonably calculated to determine the truth. Yet this is in essence the procedure upheld by the Court of Appeal in this case. Relying primarily on this Court's opinion in *Anton v. San Antonio Community Hospital* (1977) 19 Cal.3d 802 (*Anton I*), the Court of Appeal ruled that Dr. Gill received a fair hearing despite the fact that:

1) he did not have access to evidence — his monitor reports — which was directly relevant to the charges that he exhibited a pattern of substandard medical judgment and technique, and indeed, directly relevant to the case upon which the Judicial Review Committee expressed the greatest concern;

2) he was precluded from having an attorney represent him, and because he was notified in the notice of charges that no attorney would be permitted, he was wholly precluded from even making the case that he needed an attorney to represent him;[2]

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[2]It should be noted that the bylaw upheld in *Anton I* contemplated the exercise of discretion by the Judicial Review Committee in determining whether legal representation should be permitted on a case-by-case basis. It is unclear from the appellate court's opinion whether discretion was even exercised in this case; the court's suggestion that a blanket ban on legal representation comports with this Court's ruling in *Anton I* is plainly erroneous.

3) even though he did not have legal counsel, he was not permitted to present rebuttal evidence directly following the presentation of each monitor report, as he repeatedly requested, but was required to wait until after the case against him had been fully presented before he was afforded any chance to rebut the charges;

4) even though he did not have any subpoena power or right to discovery, or even access to directly relevant and potentially exculpatory information in the hospital's possession, he was required to prove "by an appropriate showing that the charges or grounds involved lack any factual basis or that such basis or any action based thereon is either arbitrary, unreasonable or capricious";

5) the hospital administrator, a person of substantial power and a witness against him, sat in on the Judicial Review Committee's deliberations; and

6) the court reviewed the "record" thus created under the "substantial evidence test".

Anton I does not support the Court of Appeal's decision in this case. To the extent this Court's rulings on the right to counsel and burden-of-proof issues provide any support for the *Gill* opinion they were entirely correct in the context of the *Anton I* decision which contemplated a full "post-deprivation" hearing before a court. Subsequent to this Court's decision in *Anton I,* the legislature in effect overturned the portion of the *Anton I* holding requiring independent review by a court. See Code of Civil Procedure § 1094.5(d). In *Anton v. San Antonio Community Hospital* (1982) 132 Cal.App.3d 638, (*Anton II*) Division 2 of the Fourth District Court of Appeal, properly ruled

that this legislation was not unconstitutional. Unfortunately, no court has analyzed the impact of the elimination of the full hearing before the court on the requisites necessary for a fair hearing at the medical staff level. While it is clear that procedural fairness may be afforded through some combination of pre-and post-deprivation review and/or administrative and court review, it is also clear that there is a trade-off: a very limited pre-deprivation or administrative review must be coupled with a full post-deprivation or court hearing. Or, to state it differently, if judicial supervision is to be limited to essentially an appellate review, there must be a reasonable opportunity to develop a complete record at the evidentiary level to assure an adequate check against error. The process afforded Dr. Gill did not permit development of such a record.

Moreover, the stakes and risks at the time of *Anton I* was decided were significantly lower. The current economic pressures and turmoil in the health care services industry are unprecedented.[3] In addition, legislation and court cases since *Anton I* have rendered the denial, restriction or termination of medical staff membership or clinical privileges devastating to the professional life of a physician. As a result of operation of California and Federal law, such adverse action imposes a stigma on a physician's good name, honor, reputation and integrity; a stigma which, at a minimum, will require that physician to defend him or herself on a number of fronts, potentially including every other medical staff where the physician has or desires to obtain privileges, the state licensing board, the Medi-Cal fraud and abuse unit, Professional Review Organizations, PPOs, HMOs and other third

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[3]Cf. *Rezzin v. Blue Cross and Blue Shield of Kansas* (D.C.Kan. 1987) 663 F.Supp. 1360.

party payors, professional liability carriers, and various enforcement arms of the Federal government including the Department of Health and Human Services, and the Justice Department.

Because of the profound changes in the law and the health care industry which have occurred since this Court's ruling in *Anton I,* the California Medical Association has carefully reconsidered the requisites of effective peer review. Based upon that review, CMA is sponsoring legislation, Senate Bill 2565 (Keene), legislation which CMA believes to strike the proper balance between the need for efficient peer review and the need for peer review committees to have the presentation of the facts requried to reach a proper conclusion. SB 2565 would codify the procedural requirements, including rights to access relevant information, retain an attorney, and have the charging body bear the burden of proof, necessary to permit effective judicial review under the substantial evidence test.

Even if this Court decides not to hear this case, this opinion should not be permitted to stand as precedent.[4,5]

B. LEGAL DISCUSSION

1. Properly Conducted, the Credentialing Process Promotes Optimal Patient Care By Ensuring That Physicians Are Not Granted Privileges To Perform

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[4]Because the legislature is currently debating this issue, decertification would also serve the goal of giving appropriate deference to the legislative branch.

[5]By filing this letter, the California Medical Association seeks only to ensure that medical staff credentialling processes be both substantively rational and procedurally fair. The Association takes no position with respect to Dr. Gill's professional qualifications.

Procedures For Which They Are Unqualified And By Ensuring That Patients Have Access To Qualified Physicians.

Medical staff membership and clinical privileges are of paramount importance not only to physicians but also to their patients, and ultimately to the community as a whole. In a nutshell, by obtaining a clinical privilege, a physician is empowered to provide those clinical services at the hospital that are specifically granted to him or by the privilege. Generally speaking, only medical staff members can be granted the privilege to admit patients to hospitals and to provide inpatient services. Consequently, medical staff membership is an integral part of a physician's practice. Moreover, as can be seen below, in addition to providing medical services to patients, medical staff members engage in quality assurance activities including credentialing (the process of reviewing the initial and ongoing competence of every physician and other health care practitioner who practices independently in the hospital) and patient-care review (the review of the ongoing quality-of-care provided throughout the hospital). Thus, not only does medical staff membership enable physicians to practice their chosen profession by providing their patients with access to hospitals, but it also provides physicians with a powerful tool for preserving high standards of medical practice.

From the patient's perspective, credentialing provides an important guarantee — a guarantee that medical care will be both available and competent. The medical staff credentialing process, if properly implemented, ensures the ongoing competence of those physicians practicing in hospitals and ensures that qualified physicians are not prohibited from becoming medical staff members or obtaining appropriate clinical privileges in a hospital which

serves the community where his or her patients reside. This dual guarantee of accessibility and quality of medical care is critical to the delivery of health care in this state and must not be eroded by the application of unlawful, vague or otherwise unfair standards or procedures.

2. Denial, Restriction Or Termination Of Medical Staff Membership And/or Appropriate Clinical Privileges Is Devastating To A Physician's Professional Reputation.

The ramifications of a denial, restriction or termination of medical staff membership or clinical privileges cannot be considered in isolation and far transcend the limitation on a physician's ability to treat patients in a particular hospital. California courts have long recognized that the refusal of access to a hospital could have the effect of denying to a qualified physician the right to fully practice his or her profession. See *Volpicelli v. Jared Sydney Torrance Memorial Hospital* (1980) 109 Cal.App.3d 242, 248 (observing "It is a generally accepted principle that a hospital's refusal to permit a physician to conduct his practice in the hospital, as a practical matter, may well have the effect of denying him the right to capably practice his profession"). As will be discussed below, legislation and court cases since this Court's decision in *Anton 1* have rendered the denial, restriction or termination of medical staff membership or clinical privileges devastating to the professional life of a physician.

Today, a physician who suffers a denial, restriction or termination of clinical privileges for medical disciplinary reasons is reported to the Board of Medical Quality Assurance, the state licensing agency for physicians. Business & Professions Code § 805. When a physician seeks to obtain or renew his or her staff privileges at any

hospital, the law now requires that this hospital contact the Board of Medical Quality Assurance to determine whether or not an "805 Report" has been filed by any other hospital. Business & Professions Code § 805.5. A failure to comply with either of these requirements is a misdemeanor. As a result of the 805 and 805.5 requirements, a physician who suffers a denial, restriction, or a revocation of medical staff privileges or membership runs the severe risk of investigation by the Board of Medical Quality Assurance and by any hospital where he or she presently enjoys membership or seeks to enjoy membership. Indeed, as a result of a recent court ruling, hospitals have a duty to ensure that the medical staff is appropriately credentialing its members and the failure to do so may be negligence. See *Elam v. College Park Hospital* (1982) 132 Cal.App.3d 332. Hospitals understandably are reluctant to grant medical staff membership to any physician who has had membership or privileges denied or restricted at another hospital, and the *Elam* obligation may well impose an affirmative duty on medical staffs to investigate carefully all 805 reports filed by other hospitals on existing medical staff members.

The effects of an adverse privileges determination are not limited the physician's ability to practice medicine in California. To the contrary, pursuant to the Health Care Quality Improvement Act (HCQIA) 42 U.S.C. §§ 11101-11152, the 805 report/805.5 investigation requirements have essentially been extended nationwide. Pursuant to the HCQIA, state boards of medical examiners must report adverse action taken by them against a physician to the United States Department of Health and Human Services (DHHS). 42 U.S.C. §§ 11132, 11134(b). Similarly, hospitals and other health care entities which take adverse action based on a physician's competence or professional conduct that adversely affects a physician's

membership or clinical privileges must report these actions to the state board of medical examiners which in turn must report them to DHHS. 42 U.S.C. §§ 11133 and 11134. Additionally, hospitals have a duty, pursuant to the HCQIA, to request information about a physician from DHHS before they initially grant the physician privileges and every two years thereafter. 42 U.S.C. § 11135. Once information concerning an adverse privilege determination is reported to DHHS, DHHS is empowered, through the Medicare and Medicaid Patient and Program Protection Act and the Peer Review Improvement Act, 42 U.S.C. §§ 1320a-7 et seq. and 1320c et seq., to initiate investigations of physicians and exclude them from the Medicare and/or Medicaid programs.[6]

Moreover, even without the operation of California or Federal law, the simple realities of the medical profession today place great importance upon the retention of medical staff privileges. Among other things, lack of privileges may hamper a physician's attempts to maintain professional liability insurance. Additionally, physicians who fail to qualify for or maintain privileges may find their opportunities to provide care to patients who receive health care benefits from HMOs, PPOs and other delivery systems and/or receive care from ambulatory care centers severely curtailed if not entirely foreclosed. Furthermore, privilege restrictions may permanently disrupt referral and consultation practices of other physicians.

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[6]While the reporting mechanism established by the HCQIA is not currently being implemented, it is expected that the national clearinghouse will be operational in the next several months.

3. The Diligent Performance Of Medical Staff Peer Review Activity Is Critical To The Health And Welfare Of The People Of This State.

In making these observations about the profound ramifications of medical staff disciplinary action, the California Medical Association does not wish to discredit in any way the importance of proper peer review. The Association applauds the peer review process. In order to ensure quality patient care, health care services must be regularly monitored and evaluated. A comprehensive quality assurance process is critical to the resolution of problems as well as to the identification of opportunities to improve patient care. Protocols and procedures must be continuously analyzed and revised to reflect new information and technologies. The clinical performance of physicians and health care providers must be repeatedly assessed so that appropriate educational information and training may be provided, and impaired or incompetent individuals may be identified *before* patients are seriously injured. See generally *Elam v. College Park Hospital* (1982) 132 Cal.App.3d 332.[7]

To be effective, this monitoring function must be performed by individuals who have both the expertise necessary to conduct these quality assurance activities and the ability to implement indicated changes. An effective peer review system provides the optimal solution. Medical staffs have both the expertise and familiarity with the health care facility, and the physicians and other health

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[7]Medical staffs are mandated by California law to assume responsibility for assuring the initial and ongoing competence of every physician, dentist, podiatrist, and in some cases, clinical psychologist, who practices in a hospital. See generally 22 California Administrative Code § 70703(b), *Unterthiner v. Desert Hospital District* (1983) 33 Cal.3d 285.

care providers involved to conduct effective peer review. Moreover, physicians generally are not paid for these activities, a factor of particular importance given current concerns over the escalating cost of health care.

4. The Credentialing Process Must Be Substantively Rational And Procedurally Fair For The Goals Of Peer Review To Be Achieved.

Just as peer review is necessary to ensure quality patient care, it is critical that the process be accomplished lawfully and fairly. The goals of peer review will be *defeated*, not promoted, if qualified physicians are wrongfully excluded from hospital medical staffs. As was discussed above, the exclusion of a competent physician does nothing to promote quality patient care. To the contrary, such exclusion disrupts continuity of care,[8] limits access by patients to competent medical care, and other physicians to competent consultation, coverage, and other assistance.[9]Moreover, not only would wrongful exclusions deprive physicians of their right to practice their chosen profession and patients of their right to enjoy an established physician-patient relationship without unwarranted interference, but they would ultimately jeopardize the continuing viability of the peer review process as a whole. As was also discussed, the peer review system in place in hospitals throughout California and indeed the nation depends upon the volunteer efforts of countless physicians who are themselves subject to the same review.

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[8]Cf. Tom's, "An Analysis of the Impact of the Loss of Primary Physician on a Patient Population" 4 Journal of Family Practice 115 (1977).

[9]Cf. *Rosner v. Eden Township Hospital Dist.* (1962) 58 Cal.2d 592 (hospital may not exclude physician because that physician advocates for quality patient care).

To ensure active participation, the peer review process must be generally perceived to be fundamentally fair and devoted to quality patient care.

5. Since Judicial Review Of Adverse Medical Staff Disciplinary Decisions Is Limited By The Substantial Evidence Test, Physicians Must Be Afforded A Reasonable Opportunity To Develop A Record Before The Peer Review Committee Sufficient To Permit Effective Judicial Review.

Numerous cases, including this Court's rule in *Anton I*, have held that hearings before an administrative agency need not comport with the formality of a court trial as long as there is a full hearing at some point. See generally *Cleveland Board of Education v. Loudermill* (1985) 470 U.S. 532; 84 L.Ed.2d 494 at 506 and 507, n.12 ("... the existence of post-termination procedures is relevant to the necessary scope of pre-termination procedures"); *Tex-Cal Land Management Inc. v. Agricultural Labor Relations Board* (1979) 24 Cal.3d 335, 345-346 ("We therefore hold that the Legislature may accord finality to the findings of a statewide agency that are supported by substantial evidence on the record considered as a whole *and are made under safeguards equivalent to those provided by the ALRA for unfair labor practice proceedings*, whether or not the California Constitution provides for that agency's exercising 'judicial power'." *Emphasis Added*).

However, the only case in which this Court has upheld a decision by the Legislature to accord finality to findings of an agency that are supported by substantial evidence which, in the absence of legislation, would be reviewable under the independent judgment test is *Tex-Cal Land Management Inc. v. Agricultural Labor Relations Board* (1979) 24 Cal.3d 347. As is pointed out above, in *Tex-Cal* this Court required "safeguards equivalent to those pro-

vided by the ALRA for unfair labor practice proceedings", before permitting the legislature to restrict judicial review to that afforded by the substantial evidence test. While that case expressly reserved the question with respect to "standards applicable to the findings of local or private agencies", *Id.* at 346, prior cases and the policy supporting them suggest that these would be treated no differently. See generally *Strumsky v. San Diego County Employees Retirement Association* (1974) 11 Cal.3d 28.

The ALRA provides significantly more procedural protection than the process afforded Dr. Gill. The ALRA incorporates a number of procedural safeguards including:

1) Separation of prosecutorial from adjudicatory functions — Labor Code § 1149:

2) Unbiased decision-makers—Labor Code § 1150;

3) The right to subpoena evidence and witnesses — Labor Code § 1151;

4) The right to an attorney — Labor Code § 1151.3;

5) Notice, written pleadings and evidentiary hearings which "shall, so far as practicable, be conducted in accordance with the Evidence Code" — Labor Code § 1160.2; and

6) A requirement that orders be accompanied by findings based on the preponderance of the reported evidence; Labor Code § 1160.3.

The Court of Appeal's decision in the *Gill* case upholding the Legislature's application of the substantial evidence test plainly cannot stand in the absence of far more

procedural protection than was afforded Dr. Gill.[10] The truncated process afforded Dr. Gill does not even approach the level of procedural protection afforded by the ALRA; it plainly did not permit development of a record sufficient to enable judicial review pursuant to the "substantial evidence test" such as to constitute any real check on the decision.

The creation of a record sufficient for court rview under the substantial evidence test would be the rare exception, not the rule, following a procedure in which the prosecutor discloses only the evidence which supports the prosecutor's case, precludes the assistance of counsel, and shifts the burden of proof to the accused. As this Court recognized in the *Tex-Cal* case, significantly more procedure is necessary to assure effective judicial review pursuant to the substantial evidence test. Given the difficulty faced by a non-lawyer in creating an understandable transcript, it is clear that Dr. Gill should have been afforded the right to retain an attorney.[11]

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[10]It should be noted that as a result of this Court's decision in *Westlake Community Hospital v. Superior Court* (1976) 17 Cal.3d 465, 482-486, physicians are foreclosed from pursuing tort remedies unless they first successfully attack the quasi-judicial proceeding in a mandamus proceeding.

[11]The Court of Appeal's references to cases involving the right to have the state pay for an attorney are plainly inapposite. A more helpful precedent is *Walters v. National Association of Radiation Survivors* (1985) 473 U.S. 305, a case which strongly suggests a right to retain counsel is necessary to assure fairness in medical staff hearings ("While counsel may well be needed to respond to opposing counsel or other forms of adversary in a trial-type proceeding, *where as here no such adversary appears, and in addition a claimant or recipient is provided with substitute safeguards such as a competent representative, a decisionmaker whose duty it is to aid the claimant, and significant concessions with respect to the claimant's burden of*

The highly ambiguous "findings" of the Judicial Review Committee strongly suggest Dr. Gill was also denied a fair hearing by improperly being required to bear the burden of proof, contrary to this Court's holding in *Anton I*.[12] Moreover, to the extent this Court's opinion in *Anton I* stands for the proposition that the medical staff need not bear the burden of proof, it cannot stand in view of the Legislature's subsequent decision to restrict review to the substantial evidence test. As discussed above, Dr. Gill had no right to subpoena evidence or witnesses, to formal discovery, or even to access to directly relevant information concerning his practice which was within the medical staff's possession. If these limitations are not counterbalanced by the availability of full court review, there is no way that he can be required to "prove his innocence" consistent with a reasonable assurance of a correct outcome.

Both of these problems were exacerbated by the fact that Dr. Gill was afforded access only to those monitor reports which the hospital felt supported its case. Indeed, the primary protection afforded by the substantial evidence test, that is, the requirement that the court review the record as a whole, is eliminated if the prosecutor is

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proof [all reasonable doubts resolved in favor of claimant] the need for counsel is considerably diminished." Id. at 333-334. [*Emphasis added*]).

[12]It should be noted that the "findings" of the Judicial Review Committee do not appear to satisfy this Court's mandate that administrative findings "bridge the analytic gap between the raw evidence and ultimate decision or order". *Topanga Association For A Scenic Community v. County of Los Angeles* (1974) 11 Cal.3d 506. The "findings" most certainly provide no basis for the *Gill* court's conclusion that the Judicial Review Committee would have come to the same conclusion had it not considered the "spleen case"; at a minimum the matter should have been remanded.

permitted to prevent disclosure of directly relevant exculpatory information within its control.[13] It must be emphasized that the peer review information pertaining to a physician's conduct in a hospital lies within the exclusive possession and control of the medical staff. A physician cannot "recreate" this evidence by the use of expert witnesses for a number of reasons, not the least of which is the substantial expense, delay, and lack of equivalent credibility likely to be assigned by the judicial review committee to the medical staff's own peer review information.[14] The legislature agrees. Evidence Code § 1157(c).

Finally, the "appearance of fairness" if not its fact demands that an adverse witness not be permitted to sit in on the "jury's" deliberations, particularly where that

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[13]See generally *Sunnyside Nurseries v. Agricultural Labor Relations Board* (1979) 13 Cal.App.3d 922, 930-931 (courts must review *entire record* and determine whether conclusion is supported by *substantial evidence*).

[14]A hypothetical may help exemplify the physician's dilemma. Consider the situation where a hospital plans to investigate the conduct of Physician A and during the investigation seeks opinions from seven doctors. Assume that five of those physicians state that Physician A provides exemplary care. The other two physicians feel otherwise. Now further assume that the hospital decides to go forward with charges and discloses to the physician only the two negative reports. Physician A must now defend him or herself, and, under the *Gill* court's holding, might never know that five other doctors concluded he or she was an excellent physician. It is clear that Physician A's defense would be significantly bolstered by access to the five positive reports, and that in the absence of any evidence of those reports in the record, a reviewing court would almost certainly conclude that the two negative reports constituted "substantial evidence" sufficient to support an adverse determination. See also *Miller v. Indiana Hospital* (3d. Cir. 1988) ____ F.2d ____ (1988 U.S.App. LEXIS 4051) ("the substantial evidence test effectively eliminates any application of the antitrust laws to defendants' actions").

witness has the power of a hospital administrator over the physician "jury" in a medical staff disciplinary case. The *Gill* court plainly erred in upholding the participation of the hospital administrator in the Judicial Review Committee's deliberations.

C. CONCLUSION

The California Medical Association believes that effective peer review is crucial to the delivery of quality patient care and that the peer review process must not be so burdensome as to eliminate active participation by the physicians and other health care practitioners who devote untold hours to quality assurance activities. The CMA also believes it is crucial to the continued viability of peer review that the process be, and be perceived to be, fundamentally fair. Incorrect decisions will defeat, not promote, the goals of peer review. The process upheld by the Court of Appeal in the *Gill* case does not afford any real check against error.

We urge this Court to decertify this case or grant the review that has been requested.

SINCERELY,

CALIFORNIA MEDICAL ASSOCIATION
CATHERINE I. HANSON
ASTRID G. MEGHRIGIAN
AUDREY L. COVNER

By: /s/ CATHERINE I. HANSON
CATHERINE I. HANSON

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APPENDIX C

STATES THAT MANDATE PEER REVIEW

1. *Arizona.*

Arizona Statute § 36-445 entitled Review of certain medical practices states:

> "The governing body of each licensed hospital or outpatient surgical center as defined in § 36-401 shall require that physicians admitted to practice in the hospital or center organize into committees or other organizational structures to review the professional practices within the hospital or center for the purposes of reducing morbidity and mortality and for the improvement of the care of patients provided in the institution. Such review shall include the nature, quality, and necessity of the care provided and the preventability of complications and deaths occurring in the hospital or center. Such review need not identify the patient or doctor by name but may use a case number or some other such designation." Ariz. Rev. Stat. § 36-445 (Supp. 1987).

2. *California.*

California Code of Regulation Title 22 § 70701 entitled Governing Body states:

> "(a) The governing body shall: (1) Adopt written bylaws in accordance with legal requirements and its community responsibility which shall include but not be limited to provision for: * * *
>
> (F) Self-government by the medical staff with respect to the professional work performed in the hospital, periodic meetings of the medical staff to

review and analyze at regular intervals their clinical experience and requirement that the medical records of the patients shall be the basis for such review and analysis. Cal. Code of Regulation tit. 22 § 70701 (1988).

California Code of Regulation Title 22 § 70703 entitled Organized Medical Staff states:

"(a) Each hospital shall have an organized medical staff responsible to the governing body for the adequacy and quality of the medical care rendered to patients in the hospital." Cal. Code of Regulation tit. 22, § 70703 (1988).

California Business & Professions Code § 2282 entitled Practice in hospital with staff of five or more physicians and surgeons without adoption of certain rules states:

"The regular practice of medicine in a licensed general or specialized hospital having five or more physicians and surgeons on the medical staff, which does not have rules established by the board of directors thereof to govern the operation of the hospital, which rules include, among other provisions, all of the following, constitutes unprofessional conduct: (a) Provision for the organization of physicians and surgeons licensed to practice in this state who are permitted to practice in the hospital into a formal medical staff with appropriate officers and bylaws and with staff appointments on an annual or biennial basis. * * * (c) Provision that the medical staff shall be self-governing with respect to the professional work performed in the hospital; that the medical staff shall meet periodically and review and analyze at regular intervals their clinical experience; and the medical records of patients shall be the basis

for such review and analysis." Cal. Bus. & Prof. Code § 2282 (West Supp. 1988).

3. *Florida.*

Florida statute § 768.40 entitled Medical Review Committee, Immunity from Liability states:

> "(1) as used in this section: (a) the term "medical review committee" or "committee" means: 1. a committee: * * * c. of a medical staff of a licensed hospital or nursing home, provided the medical staff operates pursuant to written bylaws that have been approved by the governing board of the hospital or nursing home, which committee is formed to evaluate and improve the quality of health services rendered were professionally indicated * * * (2) A medical review committee of a hospital or ambulatory surgical center or health maintenance organization shall screen, evaluate, and review the professional and medical competence of applicants to, and members of, medical staff. As a condition of licensure, each health care provider shall cooperate with a review of professional competence performed by a medical review committee." Fla. Stat. Ann. § 768.40 (West 1986 & Supp. 1988).

4. *Hawaii.*

Hawaii revised statute § 435E-34 entitled Peer review states:

> "(a) A peer review committee or committees shall be established by the trust agreement to review the qualifications of any physician and surgeon to participate or continue to participate in the interindemnity arrangement, and to review the quality of medical services rendered by any participating mem-

ber, as well as the validity of medical malpractice claims made against participating members." Haw. Rev. Stat. § 435E-34 (1976).

5. *Idaho.*

Idaho Code § 39-1392f entitled Peer review states:

"Every hospital subject to this act shall cause the hospital's medical staff to organize in-hospital medical staff committees which shall have the responsibility of reviewing the professional practices of members of the hospital's medical staff for the purpose of reducing morbidity and mortality, and for the improvement of the care of patients in the hospital. This review shall include, but not be limited to, the quality and necessity of care provided to patients." Idaho Code § 39-1392f (Supp. 1988).

6. *Indiana.*

Indiana Code § 16-10-1-6.5 entitled Management of hospital — Medical review — Civil liability states:

"(a) The governing board of the hospital shall be the supreme authority in the hospital, responsible for: * * * (2) The appointment and reappointment of the members of the medical staff, and the assignment of privileges to members of the medical staff, with the advice and recommendations of the medical staff, consistent with their individual training, experience, and other qualifications; and (3) Establishing requirements for initial and subsequent appointments to and continued service on the hospital's medical staff, consistent with the appointee's individual training, experience, and other qualifications, including such requirements as: (A) The submission of proof that a medical staff member has

qualified as a health care provider under I.C. 16-9.5; (B) The performance of patient care and related duties in a manner that is not disruptive to the delivery of quality medical care in the hospital setting; and (C) Standards of quality medical care which recognize the efficient and effective utilization of hospital resources, as developed by the medical staff." Ind. Code Ann. § 16-10-1-6.5 (Burns Supp. 1988).

7. *Maine.*

Maine Revised Statute Title 24 § 2503 entitled Hospital Duties states:

> "The governing body of every licensed hospital shall assure that: * * * 2. Provider privileges. Provider privileges extended or subsequently renewed to any physician are in accordance with those recommended by the medical staff as being consistent with that physician's training, experience, and professional competence; 3. Program for identification and prevention of medical injury. It has a program for the identification and prevention of medical injury which shall include at least the following: A. One or more professional competence committees with responsibility effectively to review the professional services rendered in the facility for the purpose of insuring quality of medical care of patients therein. Such responsibility shall include a review of the quality and necessity of medical care provided and the preventability of medical complications and deaths; . . . " Me. Rev. Stat. Ann. tit. 24, § 2503 (Supp. 1987).

8. *Nebraska.*

Nebraska Revised Statute § 71-2046 entitled Medical staff committee; utilization review committee; duties states:

> "Each hospital licensed in the State of Nebraska shall cause a medical staff committee and a utilization review committee to be formed and operated for the purpose of reviewing, from time to time, the medical and hospital care provided in such hospital and the use of such hospital facilities and for assisting individual physicians and surgeons practicing in such hospital and the administrators and nurses employed in the operation of such hospital in maintaining and providing a high standard of medical and hospital care and promoting the most efficient use of such hospital facilities." Neb. Rev. Stat. § 71-2046 (1986).

9. *Oregon.*

Oregon Revised Statute § 441.055 entitled Rules; evidence of compliance; health care facilities to insure compliance; medical staff bylaws; peer review procedure states:

> "(3) The governing body of each health care facility shall be responsible for the operation of the facility, the selection of the medical staff, and the quality of care rendered in the facility. The governing body shall: * * * (a) Insure that all health care personnel for whom state licenses, registrations or certificates are required are currently licensed, registered or certified; (b) Insure that physicians admitted to practice in the facility are granted privileges consistent with their individual training, experience and other qualifications; (c) Insure that

procedures for granting, restricting, and terminating privileges exist and that such procedures are regularly reviewed to assure their conformity to applicable law; and (d) Insure that physicians admitted to practice in the facility are organized into a medical staff in such a matter as to effectively review the professional practices of the facility for the purposes of reducing morbidity and mortality and for the improvement of patient care." Or. Rev. Stat. § 441.055 (1987).

10. *Washington.*

Washington Revised Code § 70.41.200 entitled Medical malpractice prevention program — Quality assurance committee — Sanction and grievance procedures — Information collection and reporting states:

> "(1) Every hospital shall maintain a coordinated program for the identification and prevention of medical malpractice. The program shall include at least the following: * * * (b) A medical staff privileges sanction procedure through which credentials, physical and mental capacity, and competence in delivering health care services are periodically reviewed as part of an evaluation of staff privileges; (c) The periodic review of the credentials, physical and mental capacity, and competence in delivering health care services of all persons who are employed or associated with the hospital;" . . . Wash. Rev. Code. Ann. § 70.41.200 (Supp. 1988).

APPENDIX D

BUSINESS AND PROFESSIONS CODE

§ 805. Definitions; report; confidentiality; fine for failure to make report

(a) As used in this section, the following terms have the following definitions:

(1) "Peer review body" includes:

(A) A medical or professional staff of any licensed health care facility licensed under Division 2 (commencing with Section 1200) of the Health and Safety Code.

(B) A health care service plan registered under Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code or a nonprofit hospital service plan regulated under Chapter 11a (commencing with Section 11491) of Part 2 of Division 2 of the Insurance Code.

(C) Any medical, psychological, dental, or podiatric professional society having as members at least 25 percent of the eligible licentiates in the area in which it functions (which must include at least one county), which is not organized for profit and which has been determined to be exempt from taxes pursuant to Section 23701 of the Revenue and Taxation Code.

(D) A committee organized by any entity consisting of or employing more than 25 licentiates of the same class, which functions for the purpose of reviewing the quality of professional care provided by members or employees of that entity.

(2) "Licentiate" means a physician and surgeon, podiatrist, clinical psychologist, or dentist.

(3) "Agency" means the relevant state licensing agency having regulatory jurisdiction over the licentiates listed in paragraph (2).

(4) "Staff privileges" means any arrangement under which a licentiate is allowed to practice in or provide care for patients in a health facility. Those arrangements shall include, but are not limited to, full staff privileges, active staff privileges, limited staff privileges, auxiliary staff privileges, provisional staff privileges, temporary staff privileges, courtesy staff privileges, locum tenens arrangements, and contractual arrangments to provide professional services, including, but not limited to, arrangements to provide outpatient services.

(5) "Denial or termination of privileges" includes failure or refusal to renew a contract or to renew, extend, or reestablish any staff privileges, when the action is based on medical disciplinary cause or reason.

(6) "Medical disciplinary cause or reason" means that aspect of a licentiate's competence or professional conduct which is reasonably likely to be detrimental to patient safety or to the delivery of patient care.

(7) "805 report" means the written report required under subdivision (b).

(b) The chief of staff or a medical or professional staff or other chief executive officer, medical director, or administrator of any peer review body shall file an 805 report with the relevant agency whenever any of the following actions are taken as a result of a determination of a peer review body:

(1) A licentiate's application for staff privileges or membership is denied or rejected for a medical disciplinary cause or reason.

(2) A licentiate's membership, staff privileges, or employment is terminated or revoked for a medical disciplinary cause or reason.

(3) Restrictions are imposed, or voluntarily accepted, on staff privileges, membership, or employment for a cumulative total of 30 days or more for any 12-month period, for a medical disciplinary cause or reason.

In addition to the duty to report as set forth in paragraphs (1), (2) and (3), the peer review body also has a duty to report under this section a licentiate's resignation from membership, staff, or employment following notice of an impending investigation based on information indicating medical disciplinary cause or reason.

The 805 report shall be filed within 30 days after the effective date of the denial, termination restriction, or resignation, or after the exhaustion of administrative procedures, without regard to any filing for judicial review.

An 805 report shall also be filed within 30 days following the imposition of summary suspension of staff privileges, membership, or employment, if the summary suspension remains in effect for a period in excess of 14 days.

A copy of the 805 report, and a notice advising the licentiate of his or her right to submit additional statements or other information pursuant to Section 800, shall be sent by the peer review body to the licentiate named in the report.

The information to be reported in an 805 report shall include the name of the licentiate involved, a description of the facts and circumstances of the medical disciplinary cause or reason, any any other relevant information deemed appropriate by the reporter.

A supplemental report shall also be made within 30 days following the date the licentiate is deemed to have satisfied any terms, conditions, or sanctions imposed as disciplinary action by the reporting peer review body. In performing its dissemination functions required by Section 805.5, the agency shall include a copy of a supplemental report, if any, whenever it furnishes a copy of the original 805 report.

In those instances where another peer review body is required to file an 805 report, a health care service plan or nonprofit hospital service plan is not required to file a separate report with respect to action attributable to the same medical disciplinary cause or reason.

(c) The reporting required herein shall not act as a waiver of confidentiality of medical records and committee reports. The information reported or disclosed shall be kept confidential except as provided in subdivision (c) of Section 800, provided that a copy of the report containing the information required by this section may be disclosed as required by Section 805.5 with respect to reports received on or after January 1, 1976. The Board of Medical Quality Assurance, the Board of Osteopathic Examiners, and the Board of Dental Examiners shall disclose reports as required by Section 805.5.

An 805 report shall be maintained by an agency for dissemination purposes for a period of three years after receipt.

(d) No person shall incur any civil or criminal liability as the result of making any report required by this section.

(e) Failure to make a report pursuant to this section is a misdemeanor punishable by a fine of not less than two hundred dollars ($200) nor more than one thousand two hundred dollars ($1,200).

APPENDIX E

BUSINESS AND PROFESSIONS CODE

§ 805.5. Staff privileges; grant or renewal; request for report; copy; misdemeanor

(a) Prior to granting or renewing staff privileges for any physician and surgeon, clinical psychologist, podiatrist, or dentist, any health facility licensed pursuant to Division 2 (commencing with Section 1200) of the Health and Safety Code, or any health care service plan or medical care foundation, or the medical staff of any such institution, shall request a report from the Board of Medical Quality Assurance, the Board of Osteopathic Examiners, or the Board of Dental Examiners to determine if any report has been made pursuant to Section 805 indicating that the applying physician and surgeon, clinical psychologist, podiatrist, or dentist has been denied staff privileges, been removed from a medical staff, or had his staff privileges restricted as provided in Section 805. The request shall include the name and California license number of the physician and surgeon, clinical psychologist, podiatrist, or dentist. Furnishing of a copy of the 805 report shall not cause the 805 report to be a public record.

(b) Upon a request made by, or on behalf of, an institution described in subdivision (a) or its medical staff, which is received on or after January 1, 1980, the board shall furnish a copy of any report made pursuant to Section 805. However, the board shall not send a copy of a report (1) where the denial, removal, or restriction was imposed solely because of the failure to complete medical records, (2) where the board has found the information reported is without merit, or (3) where a period of three years has elapsed since the report was submitted.

In the event that the board fails to advise such institution within 30 working days following its request for a report required by this section, the institution may grant or renew staff privileges for the physician and surgeon, clinical psychologist, podiatrist, or dentist.

(c) Any institution described in subdivision (a) or its medical staff which violates the provisions of subdivision (a) is guilty of a misdemeanor and shall be punished by a fine of not less than two hundred dollars ($200) nor more than one thousand two hundred dollars ($1,200).

APPENDIX F

STATES THAT REQUIRE REPORTING OF ADVERSE DECISIONS

1. *Alabama.*

Alabama Code § 34-24-59 entitled Reporting physician disciplinary action states:

> "(a) The chief administrative officer of each hospital shall report to the Alabama state board of medical examiners any disciplinary action taken concerning any physician when such action is related to professional ethics medical incompetence, moral turpitude, or drugs or alcohol abuse. Disciplinary actions shall include termination, reduction or resignation of hospital privileges for any of the above reasons. The report shall be in writing and be made within 60 days of the date of the action. (b) Any professional society within this state comprised primarily of physicians, which takes formal disciplinary action against a member shall report said action to the Alabama state board of medical examiners, when the action taken is related to professional ethics, medical incompetence, moral turpitude, drug or alcohol abuse. This report shall be in writing and made within 60 days of the action." Ala. Code § 34-24-59 (Supp. 1981).

2. *Alaska.*

Alaska Statute § 08.64.336 entitled Duty of physicians and hospitals to report states:

> "(b) A hospital that revokes, suspends, conditions, restricts, or refuses to grant hospital privileges to, or imposes a consultation requirement on, a person licensed to practice medicine or osteopathy in the

state shall report to the board the name and address of the person and the reasons for the action within seven working days after the action is taken. A hospital shall also report to the board the name and address of a person licensed to practice medicine or osteopathy in the state if the person resigns hospital staff privileges while under investigation by the hospital or a committee of the hospital and the investigation could result in the revocation, suspension, conditioning, or restricting of, or the refusal to grant, hospital privileges, or in the imposition of a consultation requirement." Alaska Stat. § 08.64.336 (Supp. 1987).

3. *Arizona.*

Arizona Revised Statute entitled Grounds for Disciplinary Action Duty to Report § 32-1451 states:

"B. The chief executive officer, the medical director or the medical chief of staff of a health care institution shall inform the board when the privileges of a doctor to practice in such health care institution are denied, revoked, suspended or limited because of actions by the doctor which appear to show that he is or may be medically incompetent, is or may be guilty of unprofessional conduct or is or may be mentally or physically unable to safely engage in the practice of medicine, along with a general statement of the reasons which led the health care institution to take such action. The chief executive officer, the medical director, or the medical chief of staff of a health care institution shall inform the board when a doctor under investigation resigns his privileges or when a doctor resigns in lieu of disciplinary action by the health care institution." Ariz. Rev. Stat. Ann. § 32-1451 (Supp. 1987).

4. *Arkansas.*

Arkansas Statute § 17-93-104 entitled Hospital's duty to report physician misconduct states:

> "(a)(1) A hospital licensed by or under the jurisdiction of the State of Arkansas, within sixty (60) days after taking such action as described in this section, shall report in writing to the Arkansas State Medical Board the name of any member of the medical staff or any other physician practicing in the hospital whose hospital privileges have been revoked, limited, or terminated for any cause, including resignation, together with pertinent information relating to the action. (2) The hospital shall also report any other formal disciplinary actions concerning any physician taken by the hospital upon recommendation of the medical staff relating to professional ethics, medical incompetence, moral turpitude, or drug or alcohol abuse." Ark. Stat. Ann. § 17-93-104 (1987).

5. *California.*

California Business & Professions Code § 805 entitled Definitions; report; confidentiality; liability; fine for failure to make report states:

> "(a) As used in this section, the following terms have the following definitions: * * * (2) "Licentiate" means a physician and surgeon, podiatrist, clinical psychologist, or dentist. * * * (7) "805 Report" means the written report required under subdivision (b). (b) The chief of staff of a medical or professional staff or other chief executive officer, medical director, or administrator of any peer review body shall file an 805 report with the relevant agency whenever any of the following actions are taken as a result of a determination of a peer review body: (1)

> A licentiate's application for staff privileges or membership is denied or rejected for a medical disciplinary cause or reason. (2) A licentiate's membership, staff privileges, or employment is terminated or revoked for a medical disciplinary cause or reason. (3) Restrictions are imposed, or voluntarily accepted, on staff privileges, membership, or employment for a cumulative total of 30 days or more for any 12-month period, for a medical disciplinary cause or reason. . . . The 805 Report shall be filed within 30 days after the effective date of the denial, termination, restriction, or resignation, or after the exhaustion of administrative procedures, without regard to any filing for judicial review." Cal. Bus. & Prof. Code § 805 (West Supp. 1988).

6. *Colorado.*

Colorado Revised Statute § 25-3-107 entitled Disciplinary actions reported to state board of medical examiners or podiatry board states:

> "(1) Any disciplinary action to suspend or revoke the privileges of a licensed physician or podiatrist which is taken by the governing board of a hospital required to be licensed pursuant to this part 1 or required to obtain a certificate of compliance pursuant to section 25-1-107(1)(1)(II) shall be reported to the Colorado state board of medical examiners or the Colorado podiatry board, whichever board is appropriate, in the form prescribed by said board." Colo. Rev. Stat. § 25-3-107 (Supp. 1987).

7. *Connecticut.*

Connecticut General Statute § 20-13d entitled Complaints required and permitted. Department to be notified of termination or restriction of physician's privileges.

Facilities to be notified of suspension, revocation or restriction of physician's license states:

> "(a) This state society or any county society or any physician or hospital shall within thirty days, and the board or any individual may, file a petition when such society, physician or hospital or said board or individual has any information which appears to show that a physician is or may be unable to practice medicine with reasonable skill or safety for any of the reasons listed in Section 20-13c. Petitions shall be filed with the department of health services on forms supplied by the department, shall be signed and sworn and shall set forth in detail the matters complained of. (b) Any health care facility licensed under section 19a-493 which terminates or restricts the staff membership or privileges of any physician shall, not later than fifteen days after the effective date of such action, notify the department of such action." Conn. Gen. Stat. § 20-13d (Supp. 1988).

8. *Florida.*

Florida Statute § 395.041 entitled Internal risk management program states:

> "(1) Every facility licensed under this chapter, chapter 389, or chapter 390 shall, as a part of its administrative functions, establish an internal risk management program which shall include the following components: * * * (5)(a) Each licensed facility subject to this section shall submit an annual report to the department summarizing the incident reports that have been filed in the facility for that year. The report shall be on a form prescribed by rule of the department and shall include: * * * 6. A report of all disciplinary actions pertaining to patient care taken

against any medical staff member, including the nature and cause of the action." Fla. Stat. Ann. § 395.041 (1986 & Supp. 1988).

9. *Georgia.*

Georgia Code § 88-1912 entitled Reports of disciplinary actions against persons authorized to practice medicine states:

"(a) The hospital administrator or chief executive officer of each institution subject to this chapter shall submit a written report to the Composite State Board of Medical Examiners when a person who is authorized to practice medicine in this state under Chapter 34 of Title 43 [Chapter 84-9] and who is a member of the medical staff at the institution, has medical staff privileges at the institution, or has applied for medical privileges at the institution has his medical staff privileges denied, restricted, or revoked for any reason involving the medical care given his patient. Each such administrator or officer shall also report to the board resignations from practice in that institution by persons licensed under Chapter 34 of Title 43 [Chapter 84-9]. This Code section shall not require reports of temporary suspensions for failure to comply with medical regulations. (b) The written report required by subsection (a) of this Code section shall be made within 20 working days following final action by the institution on the restriction, denial, or revocation of medical staff privileges." Ga. Code Ann. § 88-1912 (Supp. 1986).

10. *Hawaii.*

Haw. Rev. Stat. § 663-1.7 entitled Professional society; peer review committee; hospital or clinic quality assurance committee; no liability; exceptions states:

> "(d) The final peer review committee of a medical society, hospital, or clinic, or other health care facility shall report in writing every adverse decision made by it to the department of commerce and consumer affairs; provided that final peer review committee means that body whose actions are final with respect to a particular case; and provided further that in any case where there are levels in review nationally or internationally, the final peer review committee for the purposes of this subsection shall be the final committee in this State. The hospital or a clinic quality assurance committee shall report in writing to the department of commerce and consumer affairs any information which identifies patient care by any person engaged in a profession or occupation which does not meet hospital or clinic standards and which results in disciplinary action unless such information is immediately transmitted to an established peer review committee. The report shall be filed within 30 business days following an adverse decision." Haw. Rev. Stat. § 663.17 (Supp. 1987).

11. *Idaho.*

Idaho Code § 39-1393 entitled Notification of disciplinary action imposed upon physician — Confidentiality of information states:

> "The medical staff of any licensed acute care hospital in this state shall promptly notify the board of medicine of all disciplinary actions and revocations

or reductions of privileges imposed upon any physicians and surgeons licensed to practice medicine and surgery in Idaho, as respects his or her practice in or as a member of the medical staff of such hospital, including voluntary or involuntary reduction in medical staff privileges or submission to monitoring by the medical staff of the physicians [physician's] physical condition or delivery of medical services, which notice shall be given at the close of proceedings and shall generally advise of the nature of and the grounds for such action and resulting disposition. Disciplinary action based solely on compliance with hospital medical records requirements shall not be reportable." Idaho Code § 39-1393 (Supp. 1988).

12. *Illinois.*

Illinois Statute Chapter 111, paragraph 4400-23 entitled Professional conduct and capacity — Reports states:

"§ 23. Reports Relating to professional conduct and capacity. (A) Entities required to report. (1) Health Care Institutions. The chief administrator or executive officer of any health care institution licensed by the Illinois Department of Public Health shall report to the Disciplinary Board when any person's clinical privileges are terminated or are restricted based on a final determination, in accordance with that institution's by-laws or rules and regulations, that a person has either committed an act or acts which may constitute unprofessional conduct related directly to patient care, and not of such an administrative nature, or that a person may be mentally or physically disabled in such a manner as to endanger patients under that persons care. Such officer also shall report if a person accepts voluntary termination or restriction of clinical privileges in lieu

of formal action based upon unprofessional conduct related directly to patient care and not of an administrative nature, or in lieu of formal action seeking to determine whether a person maybe mentally or physically disabled in such a manner as to endanger patients under that person's care. * * * (B) Mandatory Reporting. All reports required by this Act shall be submitted to the Disciplinary Board in a timely fashion. The reports shall be filed in writing within 60 days after a determination that a report is required under this act." Ill. Ann. Stat. ch. 111, para. 4400-23 (Smith-Hurd Supp. 1987).

13. *Indiana.*

Indiana Code § 16-10-1-6.5 entitled Management of hospital — Medical staff — Medical review — Civil liability states:

"(a) The governing board of the hospital shall be the supreme authority in the hospital, responsible for: * * * (2) The appointment and reappointment of the members of the medical staff, and the assignment of privileges to members of the medical staff, with the advice and recommendations of the medical staff, consistent with their individual training, experience, and other qualifications; and * * * (b) The governing board shall report, in writing to the Indiana medical licensing board the results and circumstances of any final, substantive, and adverse disciplinary action taken by the governing board regarding a physician on the medical staff, or an applicant for the medical staff, if the action results in voluntary or involuntary resignation, termination, nonappointment, revocation, or significant reduction of clinical privileges or staff membership. Such a report shall not be made for nondisciplinary resignations nor for minor disci-

plinary action taken regarding physicians." Ind. Code. Ann. § 16-10-1-6.5 (Burns Supp. 1988).

14. *Iowa.*

Iowa Code § 147.135 entitled Peer review committees — nonliability — records and reports privileged and confidential states:

> "3. A full and confidential report concerning any final hospital disciplinary action approved by a hospital board of trustees that result in a limitation, suspension, or revocation of a physician's privilege to practice for reasons relating to the physician's professional competence or concerning any voluntary surrender or limitation of privileges for reasons relating to professional competence shall be made to the board of medical examiners by the hospital administrator or chief of medical staff within ten days of such action." Iowa Code Ann. § 147.135 (West Supp. 1988).

15. *Kansas.*

Kansas Statute § 65-28,121 entitled Report of recommendation that practice privileges of certain persons be terminated, suspended or restricted; contents of report states:

> "(a) If the medical staff of any firm, facility, corporation, institution or association which has granted practice privileges to, or which has employed or is employing, any person licensed, registered or certified by the state board of healing arts, recommends that the practice privileges of any such person be terminated, suspended or restricted for reasons relating to such person's professional competence or finds that such person has committed an act which is a ground for the revocation, suspension, or limitation

of such person's license, registration, or certification under law, the chief of the medical staff shall immediately report the same, under oath, to the state board of healing arts. If the medical staff has not made such a recommendation or finding, but the governing board of any such firm, facility, corporation, institution, or association has made such recommendation or finding, the chief administrative officer thereof shall immediately report the same, under oath, to the state board of healing arts. . . ." Kan. Stat. Ann. § 65-28,121 (1985).

16. *Kentucky.*

Kentucky Revised Statute § 311.606 entitled Medical association, hospital or its medical staff to report actions taken against licensed physicians — Violations to be reported by physicians — Reports by court clerks states:

"(1) In order to assist the board in the enforcement of KRS 311.595(19) and (20), any professional medical association or society operating in the Commonwealth of Kentucky, or any hospital or medical staff of said hospital located in the Commonwealth of Kentucky, shall report all actions taken against a licensed physician as described in KRS 311.595(19) and (20) to the board within thirty (30) days of the final adjudication of said action together with all pertinent documents to include but not limited to transcripts, pleadings, and certified copy of the final order." Ky. Rev. Stat. Ann. § 311.606 (Michie/Bobbs-Merrill 1983).

Kentucky Revised Statute § 311.550 entitled Definitions for KRS 311.530 to 311.620 and 311.990(8) to (11) states: "As used in KRS 311.530 to 311.620 and 311.990(8) to (11): (1) 'Board' means the State Board of

Medical Licensure;" . . . Ky. Rev. Stat. Ann. § 311.550 (Michie/Bobbs-Merrill 1983).

17. *Maine.*

Maine Revised Statute Title 24, § 2506 states:

"A health care provider shall, within 60 days, report in writing to the appropriate board or authority the name of any licensed, certified or registered employee or person privileged by the provider whose employment or privileges have been revoked, suspended, limited or terminated, together with pertinent information relating to that action. Any reversal, modification or change of action reported pursuant to this section shall be reported immediately to the board or authority, together with a brief statement of the reasons for that reversal, modification or change." Me. Rev. Stat. Ann. tit. 24, § 2506 (Supp. 1987).

18. *Maryland.*

Maryland Health Occupations Code § 14-512 entitled Reports to Be Made to Commission states:

> "(a) Hospitals and related institutions — (1) Each hospital and related institution shall report to the Commission: (i) If the hospital or related institution denies the application of a physician for staff privileges or limits, reduces, or ends staff privileges of a physician for reasons that might be grounds for disciplinary action under § 14-504 of this subtitle; * * * (2) The hospital or related institution shall: (i) Submit the report within 10 days of any action described in paragraph (1) of this subsection; and (ii) State in the report the reasons for its action or the nature of the formal accusation pending when the physician resigned." Md. Health Occ. Code Ann. § 14-512 (1986).

Maryland Code § 14-401 entitled Commission Established states: "There is a Commission on Medical Discipline of Maryland in the Department." Md. Health Occ. Code Ann. § 14-401 (1986).

19. *Massachusetts.*

Massachusetts General Law Chapter 111 § 53b entitled Physician's staff privileges; report of denial, restriction, revocation, or failure to renew; liability of informant; Annual disciplinary summary; penalty state:

> "Any person licensed under section fifty-one shall report to the board of registration in medicine when the licensee denies, restricts, revokes, or fails to renew staff privileges, or accepts the resignation of, any physician registered with the board as qualified to practice medicine in the commonwealth for any reason related to the registrant's competence to practice medicine or for any reason related to a complaint or allegation regarding any violation of law or regulation, or hospital, health care facility or professional medical association by-laws, whether or not the complaint or allegation specifically cites violation of a specific law, regulation or by-law. The report shall be filed within thirty days of the occurrence of the reportable action and include a statement detailing the nature and circumstances of the action, its date, and the reasons for it." Mass. Gen. Law Ann. ch. 111 § 5313 (West Supp. 1988).

Massachusetts General Law chapter 111 § 51 entitled Hospitals, institutions for unwed mothers or clinics; licensing states:

> "The department shall issue for a term of two years, and shall renew for like terms, a license, subject to revocation by it for cause, to any person,

city, town or county it deems responsible and suitable to establish or maintain a hospital, an institution for the care of unwed mothers or a clinic, which meets the requirements of the department established in accordance with its rules and regulations." Mass. Gen. Laws Ann. ch. 111 § 51 (1983 & Supp. 1988).

20. *Michigan*

Michigan Statute § 14.15(20175) entitled Disciplinary action against medical staff; notice required by facility, agency to board, department states:

"[(5)] A health facility or agency with a medical staff shall report to the appropriate licensing board and to the department not more than thirty days after any disciplinary action has been taken against a member of the medical staff, and the relevant circumstances, for any of the grounds set forth in § 16221. Mich. Stat. Ann. § 14.15 (20175) (Callaghan 1988).

21. *Minnesota.*

Minnesota Statute § 147.111 entitled Reporting Obligations states:

"Subd. 2. Institutions. Any hospital, clinic, prepaid medical plan, or other health care institution or organization located in this state shall report to the board any action taken by the institution or organization or any of its administrators or medical or other committees to revoke, suspend, restrict, or condition a physician's privilege to practice or treat patients in the institution, or as part of the organization, any denial of privileges, or any other disciplinary action." Minn. Stat. Ann. § 147.111 (West Supp. 1988)."

Minn. Stat. § 147.01 entitled Board of medical examiners states:

> "Subdivision 1. Creation; terms. The board of medical examiners consists of 11 residents of the state of Minnesota appointed by the governor." Minn. Stat. Ann. 147.01 (West Supp. 1988).

22. *Mississippi.*

Mississippi Code § 73-25-83 entitled Ground For disciplinary action by board states:

> "The board shall have authority to deny an application for licensure or other authorization to practice medicine in this state and to discipline a physician licensed or otherwise lawfully practicing within this state who, after a hearing, has been adjudged by the board as unqualified due to one or more of the following reasons: * * * (c) Having disciplinary action taken by his peers within any professional medical association or society, whether any such association or society is local, regional, state or national in scope, or being disciplined by a licensed hospital or medical staff of said hospital, or the voluntary surrender or restriction of hospital staff privileges while an investigation or disciplinary proceeding is being conducted by a licensed hospital or medical staff or medical staff committee of said hospital. Provided further, anybody taking action as set forth in this paragraph shall report this action to the board within thirty (30) days of its occurrence." Miss. Code Ann. § 73-25-83 (Supp. 1987).

Mississippi Code § 73-25-81 entitled Definition states:

> "For purposes of § 73-25-81 to § 73-25-95 the "board" shall mean the physician members of the Mississippi State Board of Medical Licensure who

have authority for the licensure and discipline of physicians in the state. Miss. Code Ann. § 73-25-81 (Supp. 1987).

23. *Missouri.*

Missouri Statute § 383.133 entitled Reports by hospitals, ambulatory surgical centers and licensing authorities, when contents, limited use, penalty states:

> "1. Beginning on January 1, 1987, the chief executive officer of any hospital or ambulatory surgical center, as such term is defined in section 197.200, RSMo, shall report to the appropriate health care professional licensing authority any disciplinary action against any health care professional or the voluntary resignation of any health care professional against whom any complaints or reports have been made which might have led to disciplinary action. 2. All reports required by this section shall be submitted within fifteen days of the final disciplinary action." Mo. Ann. Stat. § 383.130 (Vernon Supp. 1988).

Missouri Statue § 383.130 entitled Definitions states:

> "As used in sections 383.130, 383.133, and 383.500, the following terms shall mean: (1) "Disciplinary action", any final action taken by the board of trustees or similarly empowered officials of a hospital or ambulatory surgical center to reprimand, discipline, or restrict the practice of a health care professional. If the health care professional is a physician or surgeon, only such reprimands, discipline, or restrictions in response to activities which are also grounds for disciplinary actions pursuant to section 334.100, RSMo, shall be considered disciplinary actions for the purposes of this definition. * * * (4) "Licensing authority", the appropriate board or author-

> ity which is responsible for the licensing or regulation of the health care professional." Mo. Ann. Stat. § 383.133 (Vernon Supp. 1988).

24. *Montana.*

Montana Code § 37-3-403 entitled Report of prohibition or limitation on practice by hospital states:

> "Each hospital or health care facility which prohibits or limits the privilege of a physician to practice medicine within that facility shall report such action to the state board of medical examiners within 30 days after the action is taken if the action is based in whole or in part upon the commission of one or more of the offenses or the existence of one or more of the conditions set forth in § 37-3-322 or § 37-3-323(1). The report shall include the reason or reasons for the prohibition or limitation." Mont. Code Ann. § 37-3-403 (1987).

25. *Nevada.*

Nevada Statute § 630.307 entitled Filing of complaint; reporting of information concerning competence of physician states:

> "2. Any hospital, clinic or other medical facility licensed in this state, or medical society shall report to the board any change in a physician's privileges to practice medicine while the physician is under investigation and the outcome of any disciplinary action taken by that facility or society against the physician concerning the care of a patient or the competency of the physician." Nev. Rev. Stat. Ann. § 630.307 (Michie 1986).

Nevada Revised Statute § 630.050 entitled Appointment of members: Number; limitation on consecutive terms states:

> "1. The board of medical examiners consists of nine members appointed by the governor." Nev. Rev. Stat. Ann. § 630.050 (Michie 1986).

26. *New Hampshire.*

New Hampshire Revised Statute § 329:17 entitled Disciplinary Action states:

> "IV. Every licensed hospital within this state shall report to the board any disciplinary action against a person licensed by the board which involves loss of privilege other than for administrative reasons within 30 days after such disciplinary action is taken." N.H. Rev. Stat. Ann. § 329:17 (1984).

New Hampshire Revised Statue § 329:2 entitled Board; Duties states:

> "I. There shall be a board of registration in medicine consisting of 5 members; * * * II. The board shall: * * * (b) Undertake, when appropriate, disciplinary proceedings and disciplinary action against licensees, as authorized by RSA 329: 17;" . . . N.H. Rev. Stat. Ann. § 329:2 (1984).

27. *New Jersey.*

New Jersey Statute § 26:2H-12.2 entitled Disciplinary proceeding or action against physicians; notification of state board of medical examiners states:

> "A health care facility licensed pursuant to § 12 of P.L. 1971, c. 136 (C. 26:2H-12) shall notify the State Board of Medical Examiners in writing of: a. Any

disciplinary proceeding or action taken by the governing body against any physician or surgeon licensed by the board when the proceeding or action results in a physician's or surgeon's reduction or suspension of privileges or removal or resignation from the medical staff, and provide such other information relating to the proceeding or action as may be requested by the board; . . . The form of notification shall be prescribed by the Commissioner of Health, shall contain such information as may be required by the board and shall be made within 30 days of the proceeding or action, request, settlement, or award." N.J. Stat. Ann. § 26:2H-12.2 (West 1987).

28. *New Mexico.*

New Mexico Statute § 61-6-14 entitled License may be refused, revoked, or suspended; procedure; practice after suspension or revocation; penalty; notice of claim. (Effective until July 1, 1992) states:

> "D. Any hospital which provides facilities for the treatment of the general public, with licensed members of the medical profession on its staff, shall immediately report to the board the suspension or revocation of a physician's staff privileges and the reason therefor; provided, however, no report need be made on the suspension of the physician's privileges for mere failure to keep his charts current." N.M. Stat. Ann. § 61-6-14 (1978 & Repl. 1986).

New Mexico Statute § 61-6-4 entitled Definitions (Effective until July 1, 1992) states: "As used in Chapter 61, Article 6, NMSA 1978: A. 'board' means the New Mexico board of medical examiners; . . ." N.M. Stat. Ann. § 61-6-4 (1978 & Repl. 1986).

29. *New York.*

New York Public Health Statute 2803-e entitled Reporting incidents of possible professional misconduct states:

> "1. (a) Hospitals and other facilities approved pursuant to this article shall make a report or cause a report to be made within thirty days of the occurrence of any of the following: the suspension, restriction, termination or curtailment of the training, employment, association or professional privileges or the denial of the certification of completion of training of an individual licensed pursuant to the provisions of title eight of the education law or of a medical resident with such facility for reasons related in any way to alleged mental or physical impairment, incompetence, malpractice or misconduct or impairment of patient safety or welfare; the voluntary or involuntary resignation or withdrawal of association or of privileges with such facility to avoid the imposition of disciplinary measures; or the receipt of information which indicates that any professional licensee or medical resident has been convicted of a crime; the denial of staff privileges to a physician if the reasons stated for such denial are related to alleged mental or physical impairment, incompetence, malpractice, misconduct or impairment of patient safety or welfare. * * * 2. Reports of possible professional misconduct made pursuant to this section shall be made in writing to . . . the department of health in the case of physicians, physician's assistants and specialist's assistants. Written reports shall include the following information: name, address, profession and license number of the individual, a description of the action taken by the

hospital including the reason for the action and the date thereof, or the nature of the action or conduct which led to the resignation or withdrawal, and the date thereof, any criminal conviction of which the hospital has knowledge, and such other information as the education department or the department of health shall require." N.Y. Pub. Health Law § 2803-e (Consol. 1985 & Supp. 1988).

30. *North Carolina.*

New York General Statute § 131E-87 entitled Reports of disciplinary action; immunity from liability states:

"The chief administrative officer of every licensed hospital in the State shall report to the appropriate occupational licensing board any revocation, suspension or limitation of privileges to practice in that hospital. Each hospital shall also report to the board its medical staff resignations." N.C. Gen. Stat. § 131E-87 (1986).

31. *Ohio.*

Ohio Rev. Code § 4731.224 entitled Health care facilities, licenses, professional associations and insurers to report misconduct states:

"(A) Within sixty days after the completion of any formal disciplinary procedure taken by any hospital, or ambulatory surgical center as defined in section 3702.51 of the Revised Code, against any person holding a valid certificate issued pursuant to this chapter, the chief administrator or executive officer of the facility shall report to the board the name of the certificate holder, the action taken by the facility, and a summary of the underlying facts leading to the action taken. * * * As used in this division, "formal disciplinary procedure" means any proce-

> dure resulting in the revocation, restriction, reduction, or termination of clinical privileges for violations of professional ethics, or for reasons of medical incompetence, medical malpractice, or drug or alcohol abuse. "Formal disciplinary procedure" does not include any action taken for the sole reason of failure to maintain records on a timely basis or failure to attend staff or section meetings." Ohio Rev. Code Ann. § 4731.224 (Anderson 1987).

Ohio Revised Code § 4731.25 entitled Treatment providers for impaired practitioners states:

> "The state medical board, in accordance with Chapter 119. of the Revised Code, shall adopt and may amend and rescind rules establishing standards for approval of physicians and facilities as treatment providers for impaired practitioners." Ohio Rev. Code Ann. § 4731.224 (Anderson 1987).

32. *Oregon.*

Oregon Revised Statue § 441.820 entitled Procedure for termination of physician's privilege to practice medicine at health care facility; immunity from damage action for good faith report states:

> "(1) When a health care facility restricts or terminates the privileges of a physician to practice medicine at that facility, it shall promptly report, in writing, to the Board of Medical Examiners for the State of Oregon all the facts and circumstances that resulted in the restriction or termination." Or. Rev. Stat. § 441.820 (1987).

33. *Pennsylvania.*

Pennsylvania Statute Title 35 § 448.806a entitled Reporting incidents of professional misconduct states:

"(a) Reports required. — Health care facilities and hospitals, licensed under this act, shall make a report or cause a report to be made to the State Board of Medical Education and Licensure or the State Board of Osteopathic Examiners, whichever is applicable, within 60 days of the occurrence of any of the following: (1) The termination or curtailment of the employment, association, or professional privileges of a physician, licensed under the provisions of the act of July 20, 1974 (P.L. 551, No. 190), known as the "Medical Practice Act of 1974," * * * (2) The resignation or withdrawal of association or of privileges with a facility or hospital to avoid the imposition of disciplinary measures." Pa. Stat. Ann. tit. 35 § 448.806a (Purdon Supp. 1988).

34. *Rhode Island.*

Rhode Island General Laws § 23-17-23 entitled Hospital disciplinary powers states:

"(a) The board of trustees of a hospital or other appropriate authority licensed pursuant to the laws of the state is authorized to suspend, deny, revoke, or curtail the staff privileges of any staff member for good cause which shall include the grounds specified in 5-37.1-5 for unprofessional conduct. . . . (c) Any disciplinary action against a physician which involves loss of privileges other than for administrative reasons shall promptly be reported to the board of medical review by the hospital." R.I. Gen. Laws § 23-17-23 (1985).

35. *South Carolina.*

South Carolina Code § 44-7-70 entitled Report to State Board of Medical Examiners concerning action resulting

in limitation upon physician's privilege to practice in health care facility states:

> "The medical staff chief or medical director of every health care facility, as defined in 44-7-130, shall report in writing to the State Board of Medical Examiners the results of, and the circumstances concerning, any action resulting in the revocation or suspension of, or other limitation upon, a physician's privileges to practice in that health care facility. This report is not required in the case of any of the following: (1) a nondisciplinary resignation by the physician; however, any resignation occurring after an incident or occurrence which could result in the revocation or suspension of, or other limitation upon, the physician's privileges must be reported; (2) a minor disciplinary action regarding the physician's privileges in that health care facility when the action taken does not involve the revocation or suspension of, or other limitation upon, the physician's privileges to practice there; (3) a disciplinary action resulting from the physician's failure to meet recordkeeping standards; (4) a disciplinary action resulting from the physician's failure to attend meetings; or (5) other disciplinary actions as defined by regulation promulgated by the State Board of Medical Examiners." S.C. Code Ann. § 44-7-70 (Law Co-op. Supp. 1987).

36. *South Dakota.*

South Dakota Codified Laws § 36-4-22.2 entitled Report of facility suspending or revoking licensee's privilege to practice medicine therein — Immunity states:

> "Every facility licensed by the state where medicine is practiced which suspends or revokes the

> privilege of a licensee of the board of medical and osteopathic examiners to practice medicine therein for incompetence or unprofessional conduct as defined in this chapter shall report it in writing to the board including the factual basis of such revocation or suspension." S.D. Codified Laws Ann. § 36-4-22.2 (1986).

South Dakota Codified Laws § 36-4-1 entitled Board of examiners created — Appointment and terms of members — Vacancies states:

> "There is hereby created a state board of medical and osteopathic examiners, hereinafter called the board of examiners, which board shall consist of six members to be appointed by the Governor for terms of five years." S.D. Codified Laws Ann. § 36-4-1 (1986).

37. *Tennessee.*

Tenn. Code § 68-11-218 entitled Disciplinary action reports states:

"(a) The chief administrative official of each hospital shall report to the board of medical examiners any disciplinary action taken concerning any physician when such action is related to professional ethics, medical incompetence, moral turpitude, or drug or alcohol abuse. Disciplinary action shall include termination, reduction or resignation of hospital privileges for any of the above reasons. The report shall be in writing and made within sixty (60) days of the action." Tenn. Code Ann. § 68-11-218 (1987).

38. *Texas.*

Texas Revised Civil Statute Article 4495b § 5.06. entitled Reporting and confidentiality requirements states:

"(b) Each medical peer review committee or health-care entity shall report in writing to the board the results and circumstances of any professional review action that adversely affects the clinical privileges of a physician for a period longer than 30 days, accepts the surrender of clinical privileges of a physician while the physician is under an investigation by the medical peer review committee relating to possible incompetence or improper professional conduct, or in return for not conducting such an investigation or proceeding, or in the case of an entity which is a professional society or association, takes a professional review action which adversely affects the membership of a physician in the society or association. Duty to report under this section shall not be nullified through contract."

Sec. 2.01 entitled Board states:

"There is continued and recreated as an independent administrative agency of the executive branch of government the Texas State Board of Medical Examiners with powers to regulate the practice of medicine and with other duties as shall be assigned to the board." Tex. Rev. Civ. Stat. Ann. art. 4495b (Vernon Supp. 1988).

39. *Utah*

Utah Code § 58-12-43 entitled Board to endeavor to obtain information relating to adequacy and quality of medical care — Licensees and hospital personnel to furnish information — Immunity for persons furnishing information and board members states:

"(2) A hospital board shall within 60 days report in writing to the board any formal disciplinary action concerning any physician taken by the hospital upon

> the recommendation of the medical staff relating to professional ethics, medical competence, moral turpitude, or drug or alcohol abuse. This subsection shall not apply to temporary suspensions for failure to attend meetings or to maintain records on a timely basis." Utah Code Ann. § 58-12-43 (1986).

Utah Code § 58-12-2 entitled Osteopathic Medicine Licensing Act — Definitions states:

> "As used in this chapter: (1) "Board" means the Board of Osteopathic Medical Examiners as established in accordance with Chapter 1 of this title." Utah Code Ann. § 58-12-2 (1986).

40. *Vermont.*

Vermont Statute Title 26 § 1362 entitled Reports to the board states:

> "Any professional medical association, society, professional standards review organization or similarly constituted professional body, whether or not it is local, regional, state or national in scope, or any of its committees, having responsibility for the evaluation, improvement, utilization or cost of health care services and any hospital shall report to the board within 60 days of its occurrence: (1) any disciplinary action taken by it or its medical staff which significantly limits the practice privileges of a health care practitioner or leads to his suspension or expulsion from a health care and professional organization; and (2) any finding by it or its medical staff of gross violation of reasonable medical standards." Vt. Stat. Ann. tit. 26 § 1362 (Supp. 1987).

Vermont Statute Title 26 § 1311 entitled Definitions states:

"(2) 'Board' means the state board of medical practice established under section 1351 of this title; . . . " Vt. Stat. Ann. tit. 26 § 1311 (Supp. 1987).

41. *Virginia.*

Virginia Code § 54-325.1 entitled Hospitals and other health care institutions required to report disciplinary actions against certain disorders of health professionals; immunity from liability states:

"A. The chief administrative officer of every hospital or other health care institution in the Commonwealth shall, after consultation with the chief of staff of such institution, report to the appropriate board the following information regarding any person licensed under Chapters 12 (§ 54-273 et seq.) * * * (3) Any disciplinary action, including but not limited to termination of employment, termination of privileges or restriction of privileges, taken by the institution as a result of conduct involving professional ethics, professional incompetence, moral turpitude, drug addiction or alcohol abuse." Va. Code Ann. § 54-325.1 (1982).

Virginia Code § 54-273 entitled Definitions states:

"When used in this chapter unless expressly stated otherwise: 'Board' means the Virginia State Board of Medicine." Va. Code Ann. § 54-273 (Interim Supp. 1988).

42. *Washington.*

Washington Revised Code § 70.41.210 entitled Duty to report restrictions on physicians' privileges based on unprofessional conduct — Penalty states:

"The chief administrator or executive officer of a hospital shall report to the board when a physician's

clinical privileges are terminated or are restricted based on a determination, in accordance with an institution's bylaws, that a physician has either committed an act or acts which may constitute unprofessional conduct. The officer shall also report if a physician accepts voluntary termination in order to foreclose or terminate actual or hospital action to suspend, restrict, or terminate a physician's clinical privileges. Such a report shall be made within sixty days of the date action was taken by the hospital's peer review committee or the physician's acceptance of voluntary termination or restriction of privileges." Wash. Rev. Code Ann. § 70.41.210 (Supp. 1988).

Washington Revised Code § 18.72.040 entitled Board created — Composition — Legal advisor states:

"There is hereby created the 'Washington state medical disciplinary board,' which shall be composed of one holder of a valid license to practice medicine and surgery from each congressional district now existing or hereinafter created in the state and three members of the public who meet the qualifications contained in RCW 70.39.020(2) shall be appointed by the governor." Wash. Rev. Code Ann. § 18.72.040 (Supp. 1988).

43. *West Virginia.*

West Virginia Code § 30-3-14 entitled Professional discipline of physicians and podiatrists; reporting of information to board pertaining to professional malpractice and professional incompetence required; penalties; grounds for license denial and discipline of physicians and podiatrists; states:

"(b) . . . After the completion of a hospital's formal disciplinary procedure and after any resulting legal action, the chief executive officer of such hospi-

tal shall report in writing to the board within sixty days the name of any member of the medical staff or any other physician or podiatrist practicing in the hospital whose hospital privileges have been revoked, restricted, reduced, or terminated for any cause, including resignation, together with all pertinent information relating to such action. The chief executive officer shall also report any other formal disciplinary action taken against any physician or podiatrist by the hospital upon the recommendation of its medical staff relating to professional ethics, medical incompetence, medical malpractice, moral turpitude or drug or alcohol abuse. Temporary suspension for failure to maintain records on a timely basis or failure to attend staff or section meetings need not be reported." W. Va. Code § 30-3-14 (1986).

West Virginia Code § 30-3-4 entitled Definitions states:

"As used in this article: (1)'Board' means the West Virginia board of medicine established in section 5 [§ 30-3-5] of this article. Whenever any other provision of this code refers to the "medical licensing board of West Virginia," such reference shall be construed to mean and refer to the "West Virginia board of medicine" as credited and established in this article." W. Va. Code § 30-3-4 (1986).

44. *Wisconsin.*

Wisconsin Statute § 50.36 entitled Rules and standards states:

"(3) * * * (b) If, as a result of peer investigation or written notice thereof, a hospital staff member who is licensed by the medical examining board, for any reasons that include the quality of or ability to practice, loses his or her hospital staff privileges, has

his or her hospital staff privileges reduced or resigns from the hospital staff, the hospital shall so notify the medical examining board within thirty days after the loss, reduction, or resignation takes effect. Temporary suspension due to incomplete records need not be reported." Wis. Stat. Ann. 50.36 (West 1987).

45. *Wyoming.*

Wyo. Stat. § 33-26-409 entitled Health care entity reports required; malpractice states:

"(a) Each health care entity shall report: * * * (ii) On physicians when the entity: (A) Takes a professional action that adversely affects the clinical privileges of a physician for a period exceeding thirty (30) days; (B) Accepts the surrender of a physician's clinical privilege: (I) While the physician is under investigation by the entity for possible incompetence or improper professional conduct; or (II) In return for not conducting an investigation of specified in this subparagraph; or (C) In the case of an entity which is a professional society, takes a professional review action which adversely affects the membership of a physician in this society." Wyo. Stat. Ann. § 33-26-409 (Supp. 1987).

APPENDIX G

CODE OF CIVIL PROCEDURE

§ 1094.5. Review of administrative orders or decisions; filing record; extent to inquiry; abuse of discretion; relevant evidence; judgment; stay

(a) Where the writ is issued for the purpose of inquiring into the validity of any final administrative order or decision made as the result of a proceeding in which by law a hearing is required to be given, evidence is required to be taken, and discretion in the determination of facts is vested in the inferior tribunal, corporation, board, or officer, the case shall be heard by the court sitting without a jury. All or part of the record of the proceedings before the inferior tribunal, corporation, board, or officer may be filed with the petition, may be filed with respondent's points and authorities, or may be ordered to be filed by the court. Except when otherwise prescribed by statute, the cost of preparing the record shall be borne by the petitioner. Where the petitioner has proceeded pursuant to Section 68511.3 of the Government Code and the Rules of Court implementing that section and where the transcript is necessary to a proper review of the administrative proceedings, the cost of preparing the transcript shall be borne by the respondent. Where the party seeking the writ has proceeded pursuant to Section 1088.5, the administrative record shall be filed as expeditiously as possible, and may be filed with the petition, or by the respondent after payment of the costs by the petitioner, where required, or as otherwise directed by the court. If the expense of preparing all or any part of the record has been borne by the prevailing party, the expense shall be taxable as costs.

(b) The inquiry in such a case shall extend to the questions whether the respondent had proceeded without, or in excess of jurisdiction; whether there was a fair trial; and whether there was any prejudicial abuse of discretion. Abuse of discretion is established if the respondent has not proceeded in the manner required by law, the order or decision is not supported by the findings, or the findings are not supported by the evidence.

(c) Where it is claimed that the finding are not supported by the evidence, in cases in which the court is authorized by law to exercise its independent judgment on the evidence, abuse of discretion is established if the court determines that the findings are not supported by the weight of the evidence. In all other cases, abuse of discretion is established if the court determines that the findings are not supported by substantial evidence in the light of the whole record.

(d) Notwithstanding subdivision (c), in cases arising from private hospital boards or boards of directors of districts organized pursuant to The Local Hospital District Law, Division 23 (commencing with Section 32000) of the Health and Safety Code, abuse of discretion is established if the court determines that the findings are not supported by substantial evidence in the light of the whole record. However, in all cases in which the petition alleges discriminatory actions prohibited by Section 1316 of the Health and Safety Code, and the plaintiff makes a preliminary showing of substantial evidence in support of that allegation, the court shall exercise its independent judgment on the evidence and abuse of discretion shall be established if the court determines that the findings are not supported by the weight of the evidence.

APPENDIX H

MEDICAL STAFF BYLAWS

OF

MERCY HOSPITAL BAKERSFIELD

DECEMBER 1981

MEDICAL STAFF BYLAWS

Article VII Hearing and Appellate Review Procedure
Section 1. Right to Hearing and Appellate Review H-1
Section 2. Request for Hearing H-1
Section 3. Notice of Hearing H-2
Section 4. Composition of Hearing Committee H-3
Section 5. Conduct of Hearing H-4
Section 6. Appeal to the Board of Directors H-7

Article VII Hearing and Appellate Review Procedure

Section 1. Right to Hearing and Appellate Review

a. When any practitioner receives notice of a recommendation of the Executive Committee that, if ratified by decision of the Board of Directors, will adversely affect his appointment to or status as a member of the medical staff or his exercise of clinical privileges, he shall be entitled to a hearing before an ad hoc committee of the medical staff. If the recommendation of the Executive Committee following such hearing is still adverse to the affected practitioner, he shall then be entitled to an appellate review by the Board of Directors before that body makes a final decision on the matter.

b. When any practitioner receives notice of a decision by the Board of Directors that will affect his appointment to or status as a member of the medical staff or his exercise of clinical privileges, and such decision is not based on a prior adverse recommendation by the Executive Committee of the medical staff shall be entitled to a hearing by the board-medical staff committee, and if such hearing does not result in a recommendation favorable to the practitioner, to an appellate review by the Board of Directors, before that body makes a final decision on the matter.

c. All hearings and appellate reviews shall be in accordance with the procedural safeguards set forth in the Article VII to assure that the affected practitioner is accorded all rights to which he is entitled.

Section 2. Request for Hearing

a. The Administrator shall be responsible for giving prompt written notice of an adverse recommendation or decision to any affected practitioner who is entitled to a hearing or to an appellate review, by certified mail, return

receipt requested. **Any practitioner who has received notice of an adverse recommendation and wishes a review, must request a hearing of the ad hoc committee of the medical staff referenced in these by-laws within 30 days. This request should be in writing to the Administrator by certified mail, return receipt requested.

b. The failure of a practitioner to request a hearing or appellate review to which he is entitled by these bylaws within the time and in the manner herein provided shall be deemed a waiver of his right to such hearing and to any appellate review to which he might otherwise have been entitled on the matter.

c. When the waived hearing or appellate review relates to an adverse recommendation of the Executive Committee of the Medical Staff, the same shall thereupon become and remain effective against the practitioner pending the Board of Director's decision on the matter. When the waived hearing or appellate review relates to an adverse decision by the Board of Directors, the same shall thereupon become and remain effective against the practitioner in the same manner as a final decision of the Board of Directors provided for in Section 7 of this Article VII. In either of such events, the Administrator shall promptly notify the affected practitioner of his status by certified mail, return receipt requested.

Section 3. Notice of Hearing

a. Within 14 days excluding weekends and holidays after receipt of a request for a hearing from a practitioner entitled to the same, the Executive Committee or the Board of Directors, whichever is appropriate, shall schedule and arrange for such a hearing and shall, through the Administrator, notify the practitioner of the time, place and date so

**Approved Medical Staff 4/26/83

** Approved Board of Directors 5/31/83

scheduled, by certified mail, return receipt requested. The hearing date shall be not less than 30 days, not more than 60 days from the date of receipt of the request for hearing; provided, however, that a hearing for a practitioner who is under suspension which is then in effect shall be held as soon as arrangements therefore may reasonably be made, but not later than 30 days from the date of receipt of such practitioner's request for hearing.

b. The notice of hearing shall state in concise language the acts or omissions with which the practitioner is charged, a list of specific or representative charts being questioned, and/or the other reasons or subject matter that was considered in making the adverse recommendation or decision.

Section 4. Composition of Hearing Committee

a. When a hearing relates to an adverse recommendation of the Executive Committee, such hearing shall be conducted by an ad hoc hearing committee of not less than five members of the active medical staff appointed by the Chief of Staff in consultation with the Executive Committee, and one of the members so appointed shall be designated as chairman. No staff member who has actively participated in consideration of the adverse recommendation shall be appointed a member of this hearing committee.

b. When a hearing relates to an adverse decision of the Board of Directors that is contrary to the recommendation of the Executive Committee, the Board of Directors shall cause the board-medical staff committee to conduct such hearing.

Section 5. Conduct of Hearing

a. There shall be at least a majority of the members of the hearing committee present when the hearing takes place, and no member may vote by proxy.

b. An accurate record of the hearing must be kept. The mechanism shall be established by the hearing committee,

and may be accomplished by use of a court reporter, electronic recording unit, detailed transcription or by the taking of adequate minutes.

c. The personal presence of the practitioner for whom the hearing has been scheduled shall be required. A practitioner who fails without good cause to appear and proceed at such hearing shall be deemed to have waived his rights in the same manner as provided in Section 2 of this Article VII and to have accepted the adverse recommendation or decision involved, and the same shall thereupon become and remain in effect as provided in said Section 2.

d. Postponement of hearings beyond the time set forth in these bylaws shall be made only with the approval of the hearing committee. Granting of such postponements shall only be for good cause shown and in the sole discretion of the hearing committee.

e. The affected practitioner shall be entitled to be accompanied by and represented at the hearing by a member of the medical staff in good standing or by a member of his local professional society.

f. Either a hearing officer, if one is appointed, or the chairman of the hearing committee or his designee, shall preside over the hearing, determine the order of procedure during the hearing, and assure that all participants in the hearing have a reasonable opportunity to present relevant oral and documentary evidence.

g. The hearing need not be conducted strictly according to the rules of law relating to the examination of witnesses or presentation of evidence. Any relevant matter upon which responsible persons customarily rely in the conduct of serious affairs shall be considered, regardless of the existence of any common law or statutory rule which might make evidence inadmissible over objection in civil or criminal action. The practitioner for whom the hearing is being held shall, prior to or during the hearing, be entitled to

submit memoranda concerning any issue of procedure or of fact and such memoranda shall become a part of the hearing record.

h. The Executive Committee, when its action has prompted the hearing, shall appoint one of its members or some other medical staff member to represent it at the hearing to present the facts in support of its adverse recommendation and to examine witnesses. The Board of Directors, when its action has prompted the hearing, shall appoint one of its members to represent it at the hearing to present the facts in support of its adverse decision and to examine witnesses. It shall be the obligation of such representative to present appropriate evidence in support of the adverse recommendation or decision, but the affected practitioner shall thereafter be responsible for supporting his challenge to the adverse recommendation or decision by an appropriate showing that the charges or grounds involved lack any factual basis or that such basis or any action based thereon is either arbitrary, unreasonable or capricious.

i. The affected practitioner shall have the following rights: to call and examine witnesses, to introduce written evidence, to cross-examine any witnesses or any matter relevant to the issue of the hearing, to challenge any witnesses and to rebut any evidence. If the practitioner does not testify in his own behalf, he may be called and examined as if under cross-examination.

j. The hearings provided for in these bylaws are for the purpose of resolving, on an intra-professional basis, matters bearing on professional competency and conduct. Accordingly, neither the affected practitioner, nor the Executive Committee of the medical staff or the Board of Directors, shall be represented at any phase of the hearing procedure by an attorney at law unless the Board of Directors, in its discretion, permits both sides to be represented by counsel. The foregoing shall not be deemed to deprive the practi-

tioner, the Executive Committee of the medical staff, or the Board of Directors of the right to legal counsel in connection with preparation for the hearing or for a possible appeal. If a hearing officer is utilized, he may be an attorney at law.

k. The hearing committee may, without special notice, recess the hearing and reconvene the same for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. Upon conclusion of the presentation of oral and written evidence, the hearing shall be closed. The hearing committee may thereupon, at a time convenient to itself, conduct its deliberations outside the presence of the practitioner for whom the hearing was convened.

l. Within 7 working days after final adjournment of the hearing, excluding weekends and holidays, the hearing committee shall make a written report and recommendation and shall forward the same together with the hearing record and all other documentation to the Executive Committee or to the Board of Directors, whichever appointed it. The report may recommend confirmation, modification, or rejection of the original adverse recommendation of the Executive Committee or decision of the Board of Directors. Thereafter, the procedure to be followed shall be as provided in Section 2 of Article 7 of these bylaws.

Section 6. Appeal to the Board of Directors

a. Within 10 days after receipt of a notice by an affected practitioner of an adverse recommendation or decision made or adhered to after a hearing as above provided, he may, by written notice to the Board of Directors delivered through the Administrator personally or by certified mail, return receipt requested, request an appellate review by the Board of Directors. Such notice may request that the appellate review be held only on the record on which the adverse recommendation or decision is based, as supported by the

practitioner's written statement provided for below, or may request that oral argument be permitted as part of the appellate review.

b. If such appellate review is not requested within 10 days, the affected practitioner shall be deemed to have waived his right to the same, and to have accepted such adverse recommendation or decision, and the same shall become effective immediately as provided in Section 2 of this Article VII.

c. Within 10 days after receipt of such notice of request for appellate review, the Board of Directors shall schedule a date for such review, including a time and place for oral argument if such has been requested, and shall, through the Administrator, by written notice sent by certified mail, return receipt requested, notify the affected practitioner of the same. The date of the appellate review shall not be less than 10 days, nor more than 20 days, from the date of receipt of the notice of request for appellate review, except that when the practitioner requesting the review is under a suspension which is then in effect, such review shall be scheduled as soon as the arrangements for it may reasonably be made, but not more than 14 days from the date of receipt of such notice.

d. The appellate review shall be conducted by the Board of Directors or by a duly appointed appellate review committee of the Board of Directors of not less than 3 members.

e. The affected practioner shall have access to the report and record (and transcription, if any) of the ad hoc hearing committee and all other material, favorable or unfavorable, that was considered in making the adverse recommendation or decision against him. He shall have 10 days to submit a written statement in his own behalf, in which those factual and procedural matters with which he disagrees, and his reasons for such disagreement, shall be specified. This written statement may cover any matters raised at any step

APPENDIX I

Title 22, California Administrative Code
(Selected Portions)
HEALTH FACILITIES
(Hospitals)

Article 7. Administration

70701. Governing Body.

(a) The governing body shall:

(1) Adopt written bylaws in accordance with legal requirements and its community responsibility which shall include but not be limited to provision for:

(A) Identification of the purposes of the hospital and the means of fulfilling them.

(B) Appointment and reappointment of members of the medical staff.

(C) Appointment and reappointment of one or more dentists, podiatrists, and/or clinical psychologists to the medical staff respectively, when dental, podiatric, and/or clinical psychological services are provided.

(D) Formal organization of the medical staff with appropriate officers and bylaws.

(E) Membership on the medical staff which shall be restricted to physicians, dentists, podiatrists, and clinical psychologists competent in their respective fields, worthy in character and in professional ethics. No hospital shall discriminate with respect to employment, staff privileges or the provision of professional services against a licensed clinical psychologist within the scope of his/her licensure, or against a licensed physician and surgeon or podiatrist on the basis of whether the physician and surgeon or podiatrist holds an M.D., D.O. or D.P.M. degree. Wherever staffing requirements for a service mandate that the physician responsible for the service be certified or eligible for certifica-

tion by an appropriate American medical board, such position may be filled by an osteopathic physician who is certified or eligible for certification by the equivalent appropriate American Osteopathic Board.

(F) Self-government by the medical staff with respect to the professional work performed in the hospital, periodic meetings of the medical staff to review and analyze at regular intervals their clinical experience and requirement that the medical records of the patients shall be the basis for such review and analysis.

(G) Preparation and maintenance of a complete and accurate medical record for each patient.

(2) Appoint an administrator whose qualifications, authority and duties shall be defined in a written statement adopted by the governing body.

(3) The Department shall be notified in writing whenever a change of administrator occurs.

(4) Provide appropriate physical resources and personnel required to meet the needs of the patients and shall participate in planning to meet the health needs of the community.

(5) Take all reasonable steps to conform to all applicable federal, state and local laws and regulations, including those relating to licensure, fire inspection and other safety measures.

(6) Provide for the control and use of the physical and financial resources of the hospital.

(7) Require that the medical staff establish controls that are designed to ensure the achievement and maintenance of high standards of professional ethical practices including provision that all members of the medical staff be required to demonstrate their ability to perform surgical and/or other procedures competently and to the satisfaction of an appropriate committee or committees of the staff, at the

time of original application for appointment to the staff and at least every two years thereafter.

(8) Assure that medical staff by-laws, rules and regulations are subject to governing body approval, which approval shall not be withheld unreasonably.

(9) These by-laws shall include an effective formal means for the medical staff, as a liaison, to participate in the development of all hospital policy.

NOTE: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Sections 1276, 1315, 1316 and 1316.5, Health and Safety Code.

HISTORY:

1. Amendment filed 2-8-83; designated effective 3-2-83 (Register 83, No. 7).

2. Editorial correction of subsection (a)(7) filed 8-31-83; effective thirtieth day thereafter (Register 83, No. 36).

70703. Organized Medical Staff.

(a) Each hospital shall have an organized medical staff responsible to the governing body for the adequacy and quality of the medical care rendered to patients in the hospital.

(1) The medical staff shall be composed of physicians and, where dental or podiatric services are provided, dentists or podiatrists.

(2) Where clinical psychological services are provided, clinical psychologists may be appointed to the medical staff subject to the by-laws, rules and regulations of the hospital.

(b) The medical staff, by vote of the members and with the approval of the governing body, shall adopt written by-laws which provide formal procedures for the evaluation of staff applications and credentials, appointments, reappoint-

ments, assignment of clinical privileges, appeals mechanisms and such other subjects or conditions which the medical staff and governing body deem appropriate. The medical staff shall abide by and establish a means of enforcement of its by-laws. Medical staff by-laws, rules and regulations shall not deny or restrict within the scope of their licensure, the voting rights of staff members or assign staff members to any special class or category of staff membership, based upon whether such staff members hold an M.D., D.O., D.P.M. or D.D.S. degree or clinical psychology license.

(c) The medical staff shall meet regularly. Minutes of each meeting shall be retained and filed at the hospital.

(d) The medical staff shall provide in its bylaws, rules and regulations for the functions to be performed by the following committees: executive credentials, medical records, tissue, utilization review, infections and pharmacy and therapeutics. In those hospitals where appropriate, these functions may be performed by a committee of the whole or its equivalent. These committees shall make reports of their activities and recommendations to the executive committee and the governing body as frequently as necessary and at least quarterly.

(e) The medical staff shall provide in its bylaws, rules and regulations for appropriate practices and procedures to be observed in the various departments of the hospital. In this connection the practice of division of fees, under any guise whatsoever, shall be prohibited and any such division of fees shall be cause for exclusion from the staff.

(f) The medical staff shall provide for availability of a staff physician for emergencies among the in-hospital population in the event that the attending physician or his alternate is not available.

(g) The medical staff shall participate in a continuing program of professional education. The results of

retrospective medical care evaluation shall be used to determine the continuing education needs. Evidence of participation in such programs shall be available.

(h) The medical staff shall provide at least one physician to participate as a member of the hospital infection control committee.

(i) The medical staff shall develop criteria under which consultation will be required. These criteria shall not preclude the requirement for consultations on any patient when the director of the service, chairman of a department or the chief of staff determines a patient will benefit from such consultation.

NOTE: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Sections 1276, 1315, 1316 and 1316.5, Health and Safety Code.

HISTORY:

1. Amendment filed 2-8-83; designated effective 3-2-83 (Register 83, No. 7).

PROOF OF SERVICE BY MAIL

I am a citizen of the United States and a resident of the City and County of Los Angeles; I am over the age of eighteen years and not a party to the within action; my business address is: 1706 Maple Avenue, Los Angeles, California.

On August 15, 1988, I served the within Petition for Writ of Certiorari in re: "Zora S. Gill, M.D. vs. Mercy Hospital and the Medical Staff of Mercy Hospital" in the United States Supreme Court, October Term 1988, No. .....;

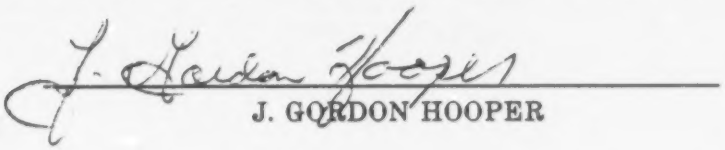
On the Parties in said action, by placing three copies thereof enclosed in a sealed envelope with postage fully prepaid, in the United States post office mail box at Los Angeles, California, addressed as follows:

Jay D. Christensen, Esq.
Ellingsen, Christensen & West
333 South Grand Ave.
Thirty-third Floor
Los Angeles, CA 90071

All Parties required to be served have been served.

I certify, under penalty of perjury, that the foregoing is true and correct.

Executed on August 15, 1988, at Los Angeles, California



J. GORDON HOOPER

(2)

No. 88-301

Supreme Court, U.S.
FILED
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JOSEPH F. SPANIOL, JR.
CLERK

In The

Supreme Court of the United States

October Term, 1988

—o—

ZORA S. GILL, M.D.,

Petitioner,

v.

MERCY HOSPITAL AND THE MEDICAL STAFF OF MERCY HOSPITAL,

Respondents.

—o—

OPPOSITION TO PETITION FOR WRIT OF CERTIORARI TO THE CALIFORNIA COURT OF APPEAL

—o—

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TABLE OF CONTENTS

	Page
STATEMENT OF THE CASE	1
SUMMARY OF ARGUMENT	3
ARGUMENT	4
I. NO ISSUE RAISED BY THIS PETITION WARRANTS EXERCISE OF THE COURT'S DISCRETION TO GRANT CERTIORARI	4
II. PEER REVIEW ACTIONS BY PRIVATE CALIFORNIA HOSPITALS DO NOT CONSTITUTE FOURTEENTH AMENDMENT STATE ACTION	5
III. THE FEDERAL HEALTH CARE QUALITY IMPROVEMENT ACT HAS NO APPLICABILITY TO THIS CASE	8
IV. THE PROCESS APPLIED TO PETITIONER WAS FAIR AND COMPLIED WITH APPLICABLE STATE LAW	10
V. THE CALIFORNIA ADMINISTRATIVE MANDATE STATUTE DOES NOT VIOLATE THE EQUAL PROTECTION CLAUSE	10
VI. THE PETITION VIOLATES SUPREME COURT RULE 21.4 AND, THEREFORE, SHOULD NOT HAVE BEEN RECEIVED AND FILED	11
CONCLUSION	11

TABLE OF AUTHORITIES

Page(s)

FEDERAL CASES

Blum v. Yaretsky, 457 U.S. 991, 73 L.Ed.2d 534, 102 S.Ct. 2777 (1982) 5, 6

Briscoe v. Bock, 540 F.2d 392 (8th Cir. 1976) 5

Greco v. Orange Memorial Hospital Corp., 513 F.2d 873 (5th Cir. 1975) 5

Hodge v. Paoli Memorial Hospital, 576 F.2d 563 (3rd Cir. 1978) 5

Loh-Seng Yo v. Cibola General Hospital, 706 F.2d 306 (10th Cir. 1983) 5

Madry v. Sorel, 558 F.2d 303 (5th Cir. 1977), *cert. denied*, 434 U.S. 1086 (1978) 5

Musso v. Suriano, 586 F.2d 59 (7th Cir. 1978), *cert. denied*, 440 U.S. 971 (1979) 5

Parker v. Brown, 317 U.S. 341, 63 S.Ct. 307, 87 L.Ed. 315 (1943) 7

Patrick v. Burget, 486 U.S. —, 100 L.Ed.2d 83, 108 S.Ct. 1658 (1988) 5, 7

Schlein v. Milford Hospital, Inc., 561 F.2d 427 (2nd Cir. 1977) 5

Sarin v. Samaritan Health Center, 813 F.2d 755 (6th Cir. 1987) 5

Taylor v. St. Vincent's Hospital, 523 F.2d 75 (9th Cir. 1975), *cert. denied*, 424 U.S. 948 (1976) 5

Watkins v. Mercy Hospital Center, 520 F.2d 894 (9th Cir. 1975) 5

FEDERAL

CONSTITUTION

Fourteenth Amendment 6

TABLE OF AUTHORITIES—Continued

Page(s)

STATUTES

42 U.S.C. 11111, *et seq.*, Health Care Quality Improvement Act of 1986 ..... 4, 8

42 U.S.C. 11112(a)(3), Health Care Quality Improvement Act of 1986 8

42 U.S.C. 11112(b), Health Care Quality Improvement Act of 1986 9

OTHER

Congressional Record, October 17, 1987, p. H 11591 10

House Report on H.R. 5540 (Bill adopted as the Health Care Quality Improvement Act of 1986) 9

Report of the House of Representatives, Committee on Energy and Commerce on the Healthcare Quality Improvement Act of 1986, Rpt. No. 99-903, pp. 10-11 9

Supreme Court Rule 17.1(b) 4

Supreme Court Rule 17.1(c) 4

Supreme Court Rule 21.4 10

CALIFORNIA

STATUTE

California Code of Civil Procedure, Section 1094.5, Subsection 1094.5(d) (the California Administrative Mandate Statute) 10

STATEMENT OF THE CASE

Respondent, Mercy Hospital, is a private hospital located in Bakersfield, California. Petitioner is a member of Respondent's Medical Staff with privileges to perform certain general and vascular surgical procedures. This dispute involves the Hospital's decision, based on the recommendation of its Medical Staff, to deny Petitioner's request for privileges to perform certain additional surgical procedures which Petitioner had performed on a provisional basis.

Petitioner was appointed to the Provisional category of Hospital's Medical Staff on October 25, 1983. As a provisional member, he was subject to formal monitoring of his performance in all of his surgical procedures. Under Hospital's medical staff bylaws, Petitioner was required to demonstrate sufficient proficiency in all requested surgical procedures to advance to unmonitored status within two years.

In 1985, the Medical Staff's surgical control and medical executive committees recommended that Petitioner be granted unmonitored status to perform some procedures,[1] but that his privileges to perform other procedures be terminated.

Petitioner requested and was given a full, evidentiary hearing before a medical peer review committee to review the denial of certain privileges. The hearing process complied in all respects with both Hospital bylaws and appli-

---

1. These were hernia repair, appendectomy, skin biopsy, pilonidal cyst, routine gallbladders and arteriovenous shunts and arteriovenous fistulas performed in an extremity for access.

cable California law. Prior to the hearing, Petitioner received detailed notice of the deficiencies which had been observed in his surgical practice together with copies of all critical monitor reports and copies of all applicable patient records. At the hearing, which was conducted on April 1, 1986, Petitioner was represented by a physician advocate of his choice.[2] He confronted and examined witnesses against him and presented evidence in his behalf. The hearing was conducted before a panel of physicians who had had no prior involvement in the matter.

Following the hearing, the peer review committee upheld the surgical and executive committees' recommendation. This decision was based on a detailed review of thirteen cases and on the expert opinion of his monitors and of a hospital-based radiologist. The committee concluded that Petitioner had demonstrated poor medical judgment and poor surgical technique in several more complicated surgical cases. Among other problems he had incorrectly sized a femoral-femoral artery graft; he had used poor surgical technique in performing a vascular access graft which failed in a short time; he improperly tied a knot inside an already occluded artery (which the monitor required him to remove); he handled tissue roughly and broke through a portion of a vein graft; he had a "noticeable tremor" while placing an anastomosis which leaked enough to require additional suturing; his monitor had to intervene to prevent him from performing a complicated gallbladder operation

---

2. Under California law and the applicable bylaws, Petitioner was not entitled to be represented at the peer review hearing by legal counsel. He was represented by legal counsel, however, at the extensive appellate review of the matter before the Hospital's Board of Directors.

when preoperative tests showed that the involved tissue would not have stood the procedure; he repeatedly used poor suturing technique; he performed an unnecessary appendectomy during an unrelated procedure despite risk of infection due to cecal contamination; he failed either to order imaging studies or to proceed expeditiously to surgery to save a young spleen-injury victim who was in serious danger of bleeding to death; he scheduled a hernia operation for a patient whose medical condition was too serious for that procedure; and he mismanaged a patient's postsurgical complication.

Following an extensive appellate review hearing before the Hospital's Board, at which Petitioner was represented by legal counsel, the Board upheld the Medical Staff's recommendation. Petitioner then filed a Petition for Writ of Mandate in Kern County Superior Court, seeking to overturn the Hospital's decision. That Petition was denied by order dated December 23, 1986. Petitioner appealed the denial and his appeal was denied by the California Court of Appeal on March 1, 1988. The California Supreme Court denied Petitioner's Petition for review.

SUMMARY OF ARGUMENT

Petitioner's claims are based on the assumption that medical peer review actions by *private* California hospitals constitute State Action because California requires hospitals to conduct peer review and to report adverse peer review actions to the State medical board. This assumption is false. Federal courts has consistently held that peer

review by private hospitals is not State Action. Moreover, peer review actions by private California hospitals cannot be State Action, since no state entity or official controls the substantive decisions. Such actions are made by private individuals on the basis of professional standards which are not established by the State. They cannot fairly be attributed to the State.

The process applied to Petitioner was fair and complied in all respects with applicable bylaws and a well-developed body of California law which has not been affected by the Health Care Quality Improvement Act, 42 U.S.C. 11111, *et seq.*

ARGUMENT

I. No Issue Raised by This Petition Warrants Exercise of the Court's Discretion to Grant Certiorari

This is neither a case in which a state court of last resort has "decided a federal question in a way in conflict with the decision of another state court of last resort or of a federal court of appeals" (Supreme Court Rule 17.1(b)), nor a case in which a state court "has decided an important question of federal law [which] should be settled by this Court, or [which] has decided a federal question in any way in conflict with applicable decisions of this Court" (Supreme Court Rule 17.1(c)).

Of course the California Court of Appeal is not a state court of last resort. Even if it were, its decision in this case is fully consistent with every federal and state court

which has considered the question of whether peer review decisions by private hospitals constitutes Fourteenth Amendment State Action. No court has ever held that private hospital peer review decisions constitute State Action. To the contrary, seven Circuit Courts of Appeal have rejected that proposition. *Schlein v. Milford Hospital, Inc.*, 561 F.2d 427 (2nd Cir. 1977); *Hodge v. Paoli Memorial Hospital*, 576 F.2d 563 (3rd Cir. 1978); *Greco v. Orange Memorial Hospital Corp.*, 513 F.2d 873 (5th Cir. 1975); *Madry v. Sorel*, 558 F.2d 303 (5th Cir. 1977), *cert. denied*, 434 U.S. 1086 (1978); *Sarin v. Samaritan Health Center*, 813 F.2d 755 (6th Cir. 1987); *Musso v. Suriano*, 586 F.2d 59 (7th Cir. 1978), *cert. denied*, 440 U.S. 971 (1979); *Briscoe v. Bock*, 540 F.2d 392 (8th Cir. 1976); *Watkins v. Mercy Hospital Center*, 520 F.2d 894 (9th Cir. 1975); *Taylor v. St. Vincent's Hospital*, 523 F.2d 75 (9th Cir. 1975), *cert. denied*, 424 U.S. 948 (1976); *Loh-Seng Yo v. Cibola General Hospital*, 706 F.2d 306 (10th Cir. 1983).

Since the inapplicability of Fourteenth Amendment State Action to private peer review is so well established, no issue raised by this Petition is of enough importance to warrant this Court's resolution. Moreover, as is discussed below, the decision in this case is fully consistent with this Court's analysis in both *Patrick v. Burget*, 486 U.S. —, 100 L.Ed.2d 83, 108 S.Ct. 1658 (1988) and *Blum v. Yaretsky*, 457 U.S. 991, 73 L.Ed.2d 534, 102 S.Ct. 2777 (1982).

II. Peer Review Actions by Private California Hospitals Do Not Constitute Fourteenth Amendment State Action

Petitioner asserts, without citation of any authority, that private hospital peer review actions in California

must constitute State Action under the Fourteenth Amendment, because California licensure regulations and liability standards require private hospitals to monitor and appropriately limit the clinical privileges of Medical Staff members and because adverse peer review actions must be reported to the state medical board.

That assertion is flatly inconsistent with this Court's State Action analysis as stated in *Blum, supra.* There the State of New York, through Medicaid regulations required private physicians to use a prescribed form to certify the medical necessity of skilled nursing facility ("SNF") care for Medicaid patients. It also required private SNFs to complete and submit patient assessment forms, to operate utilization review committees ("URCs") and to discharge or transfer patients whose continued stay was inappropriate. Facilities which failed to do so were subject to fines.

Medicaid patients subject to transfer or discharge claimed that the URC decisions were State Action and that they were entitled to due process hearings prior to transfer or discharge. This Court rejected that claim, however, ruling that although the state had required URC decisions to be made and reported, it had not exercised direct control over the substantive decisions themselves. "Those decisions ultimately turn on medical judgments made by private parties according to professional standards that are not established by the State." 457 U.S. at 1009. The "regulations themselves do not dictate the decision to discharge or transfer in a particular case." 457 U.S. at 1010. And, "although federal law requires state officials to review these assessments [citation omitted] nothing in the

regulations authorizes the officials to approve or disapprove decisions either to retain or discharge particular patients. . . ." *Id.*

Likewise, California licensure and reporting regulations may require hospitals to conduct peer review and to report the results, but it is *private* rather than *state* actors who decide whether or not to approve particular clinical privileges for particular physicians. Those decisions also "turn on medical judgments made by private parties according to professional standards which are not established by the State." It cannot, therefore, "be said that the State is responsible for the specific conduct of which [Petitioner] complains." 457 U.S. at 1004.

In its recent decision in *Patrick, supra,* this Court adopted a consistent analysis to determine whether the State of Oregon had exercised sufficient active supervision over private peer review actions to protect them from federal antitrust scrutiny. Although Oregon required private hospitals to conduct peer review, to limit clinical privileges as appropriate and to report limitations to the state medical board, no state agency exercised power actually to control the individual decisions. Private peer review actions were, therefore, not State action under the doctrine of *Parker v. Brown,* 317 U.S. 341, 83 S.Ct. 307, 87 L.Ed. 315 (1943).

In so ruling, this Court again recognized that private medical peer review actions do not become transformed into the action of states just because states require peer review to be done and require the results to be reported.

III. The Federal Health Care Quality Improvement Act Has No Applicability To This Case

Petitioner claims that the procedural safeguards which ought to have applied to his hearing before Hospital's medical staff are affected by the reporting and limited immunity provisions of the federal Health Care Quality Improvement Act of 1986, 42 U.S.C. Sections 11111, *et seq.* ("HCQIA").

That claim simply cannot be made in good faith. HCQIA was not enacted until October 17, 1986, over six months *after* Respondent's Medical Staff hearing, and its peer review reporting provisions have not yet been implemented. HCQIA simply has not and will not apply in any way to this peer review action.

Moreover, HCQIA does not, as Petitioner suggests, reflect a Congressional policy to modify state peer review procedural requirements in effect at the time HCQIA was adopted.

In order to qualify for immunity under HCQIA, a professional review action must, *inter alia*, be taken "after adequate notice and hearing procedures are afforded to the physician involved or after such other procedures as are fair to the physician under the circumstances. . . ." 42 U.S.C. Section 11112(a)(3). Peer review actions are presumed to qualify for immunity "unless the presumption is rebutted by a preponderance of the evidence."

Congress established two ways for a professional review entity to comply with the "adequate notice and hearing" requirement. One is simply to follow the existing state law applicable to such hearings; the other is to follow

a set of procedural steps, set forth in Section 11112(b) of the Act, which constitute a procedural "safe harbor." Section 11112(b) makes it clear that a "professional review body's failure to meet the conditions described in this subsection shall not, in itself, constitute failure to meet the [fair notice and hearing requirement]."

The alternative nature of the notice and hearing provisions was described in the House Report on H.R. 5540 (the Bill which was adopted as the Act):

> "If the procedures specified in that subsection are not precisely of the character spelled out in subsection [11112(b)], the test of 'adequacy' may still be met under other prevailing law. The Committee is aware, for example, that some courts have already carefully spelled out the different requirements for certain professional review activities or actions, such as procedures regarding applicants for privileges at a hospital. In those situations, compliance with applicable law should satisfy the 'adequacy' requirement even where such activities or actions require different or fewer rights than the ones specified under subsection [11112(b)]." Report of the House of Representatives, Committee on Energy and Commerce on the Healthcare Quality Improvement Act of 1986, Rpt. No. 99-903, pp. 10-11.

The "safe harbor" rights specified under subsection 11112(b) include the physician's right, at the hearing, to be "represented by an attorney or other person of the physician's choice."

On the day the Act was passed, California Congressman, Henry Waxman, reiterated that the provisions of subsection 11112(b) are not intended to change existing law governing peer review hearings:

> "Those who have raised the due process objections have obviously misconstrued the effect of Section [11112(b)] which states that a professional review board's failure to meet the adequate due process provisions set forth in the bill shall not, in itself, constitute the failure to meet adequate due process for purposes of obtaining immunity. A simple reading of this language reveals that it does nothing whatsoever to lessen a physician's due process rights. As carefully explained in the report accompanying H.R. 5540, this language simply means that those who choose to rely on current law—rather than the specific provisions of H.R. 5540 regarding due process may do so." *Congressional Record,* October 17, 1987, p. H 11591.

So, far from upsetting existing California law on medical staff hearings, the Act allows hospitals to continue to follow existing law.

IV. The Process Applied To Petitioner Was Fair And Complied With Applicable State Law

As is detailed in the Court of Appeal decision appended to the Petition, California courts have carefully defined the elements of "fair procedure" which must attend medical peer review actions. Each of the procedural arguments which Petitioner advances here is dealt with appropriately in the California Court of Appeal decision.

V. The California Administrative Mandate Statute Does Not Violate The Equal Protection Clause

Petitioner argues that the California Administrative Mandate statute, Section 1094.5 of the California Code of Civil Procedure, violates the Equal Protection Clause by adopting a less stringent standard of judicial review for peer review actions by private hospitals than for public

hospitals. In support of this argument, Petitioner misquotes the section in point. The version of Section 1094.5 (d) quoted at page 22 of the Petition is out of date. The current Section 1094(d), which is reprinted correctly in Appendix G-1 of the Petition, specifies that the same standard of judicial review applies to private and public district hospitals.

VI. The Petition Violates Supreme Court Rule 21.4 And, Therefore, Should Not Have Been Received And Filed

Appendix B to the Petition is a letter brief by the California Medical Association. It was used in Petitioner's unsuccessful attempt to obtain review by the California Supreme Court. Its inclusion in the Petition can be for no purpose other than to support the Petition. As such, it directly violates Rule 21.4 and disqualifies the Petition from being received or filed.

CONCLUSION

The Petition should be denied.

Respectfully submitted,

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